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EDITORIAL FOREWORD

The majority of the papers in this issue of the JOURNAL is dedicated to Child Mental Health as an outgrowth of the southeastern regional meeting of the American Association of Psychiatric Services for Children held in May, 1974, in Charlottesville, Virginia.

It is entirely conceivable that future issues could serve as a forum highlighting other such meetings where quality papers can be more fully disseminated through formal publication.

Professional associations interested in presenting their format for publication in further issues of the JOURNAL should contact the Editors.

MEASURING ASSERTIVE BEHAVIOR WITH QUESTIONNAIRES: AN AID IN ASSERTIVE TRAINING THERAPY

James R. Frazier
Child Development Institute
Chapel Hill, North Carolina

E. Jeanine Carver
Duke University
Durham, North Carolina

The phrase assertive training as originally used by Wolpe (1958) referred not only to the therapeutic shaping of appropriate aggressive behavior of clients who were passive, but also to the encouragement of expression of friendly, affectionate feelings by person, incapable of such behavior. In clinical practice clients typically exhibit both lack of aggression and inhibition of affection, and the therapeutic task becomes one of deciding—with the clients help—which behavioral difficulty to remediate. This decision becomes particularly difficult if a behavioral therapy procedure is employed, with the resulting necessity to define and measure the difficulty in question. The following discussion attempts to describe several questionnaires available to the clinician which may be useful in defining the client's difficulties.

One of the problems in determining which procedure will be most effective for non-assertive clients is the absence of an adequate description of the client's behavioral characteristics brought to the therapy situation. Obviously the central problem concerns a lack of self-assertion and this information typically is included in the presenting complaint, the data collection procedure being an interview which summarizes the client's relevant life history. Wolpe and Lazarus (1966) supplement the interview with a questionnaire depicting specific life situations in which the emission of assertive behavior is desirable. Each question is discussed with the client to reveal specific areas and degrees of assertive and non-assertive behavior in interpersonal situations. Wolpe (1958) and Wolpe and Lazarus (1966) also have used the Willoughby Personality Schedule to gather evidence of specific fears in interpersonal situations. Designed as a test for neuroticism (persistent unadaptive anxiety reactions), this 25 question test employs a 5-point scale for each question, with high scores indicating excessive anxiety reactions. Its content appears to measure both assertive and non-assertive behavior.

Working on the assumption that assertive behavior is a broad, heterogeneous and situation-specific response class, McFall and Lillesand (1971) re-defined assertive behavior as the ability to refuse unreasonable requests. A paper and pencil self-report inventory of refusal behavior was constructed, labeled the Conflict Resolution Inventory (CRI). In final form the CRI consisted of a 35-item inventory of responses to specific refusal situations. The CRI yields one general attitudinal measure, the global self-rating of assertive-refusal problems, and three specific measures: assertive, non-assertive and difference scores.

The CRI appears to be particularly useful with college-age clients, since the simulated refusal situations were obtained from written statements by college

students of both sexes. The refusal situations approximate a variety of campus situations in which the client must assert his rights. These practical, everyday situations provide the therapist and client an excellent opportunity to work on the client's non-assertive behavior in a real life context. For example, the therapist might wish to set up a series of situations in the client's dorm room, provide the necessary structure, and rehearse the appropriate assertive responses with the client to the simulated unreasonable demands. Student lines at cafeterias, football games, registration tables, all afford the client-therapist team excellent opportunities to shape appropriate aggressive behavior. Used with imagination the CRI presents a wealth of situational material appropriate to college-age clients. Clinicians operating from a college counseling base would find these "in vivo" situations both an economic use of client-therapist energies and an effective therapeutic approach to the client's problems in living.

As indicated earlier the original definition of the term assertive includes expression of both resentment and anger, and friendly, affectionate feelings. In some circumstances direct assertion may have undesirable consequence, and the therapist would be concerned with encouraging only those assertive acts which were appropriate and adaptive. Bates and Zimmerman (1971) stated that non-assertion may be adaptive under certain conditions and adopted the term "constriction" to denote inappropriate non-assertion, constriction defined by covert responses interfering with interpersonal expression. A construction scale was formulated to screen clients who might benefit from assertive training, using a functional behavior analysis as the conceptual framework. Test items contained three elements: stimulus person, stimulus situation and response. Stimulus persons varied along the continua of number and familiarity, situation varied according to general context and controlling contingencies, and responses varied on a suppression-expression continuum. Like the CRI, the constriction scale is based on middle-classed college freshmen, male and female, and its use by the social worker would be most appropriate with that population. The advantages of using the constriction scale, as opposed to the CRI, lie in the former's ability to pinpoint specific problem areas requiring behavioral modification. Bates and Zimmerman (1971) suggest appropriate cut-off scores to enable the clinician to decide the advisability of assertion training for each client. As indicated in the above discussion, the term constriction, and the resulting data obtained from the constriction scale, give the social worker somewhat different information about non-assertive behavior than the material obtained from the CRI. The constriction scale appears to be related more to intrapersonal aspects of non-assertion than the more situational variables stressed by the CRI. The clinician should be aware of the different emphases before deciding which scale to use.

The final scale to be discussed, the Anger Expressiveness Test (Wagner, 1968), places main emphasis on situations under which anger (assertive behavior) can be expressed. Expressions of hostility, domination, independence, etc., are measured by 24 anger-provoking situations which comprise the test. Wagner (1968) used this instrument in the context of psychodrama, telling clients to respond as if a particular situation were happening, and providing examples of responding and feedback. Taken in this context, the therapist might profitably use this instrument to assess client's potential for group therapy; therapeutic con-

tent might revolve around the collective inability of the group to express the above mentioned feelings. Both the effective and ineffective expression of anger by the client can be assessed using this instrument. Immediate feedback within the group as well as delayed feedback by video tape recording would be effective re-learning procedures.

The therapist must decide which questionnaire yields maximum practical benefit for each situation and client. This decision will be based, in part, on one's definition of assertive behavior. The questionnaires cited previously, with the brief descriptions of each rationale, should enable the therapist to decide whether or not the client's presenting difficulties match those behavioral areas measured by the questionnaire. In situations where the area covered by a questionnaire appears too narrowly focused, combinations of appropriate questionnaires could be administered. When deciding upon the selection of a questionnaire, one must remember that the therapist's definition of non-assertion and the client's non-assertive behavior are two separate issues; it is imperative that this distinction be kept in mind, and that the therapist be keenly aware of his own assumptions about what constitutes appropriate assertive behavior. Furthermore, appropriate assertive behavior certainly encompasses a broader response spectrum than aggression, a fact typically overlooked by therapists when faced with a client who does not exhibit appropriate aggression. Certainly the questionnaire cited in this paper attest to this fact.

Regardless of the instrument selected, each question and answer should be explored with the client to determine those personal feelings and attitudes which contribute to his non-assertive behavior. Generally speaking, most clients have maladaptive anxiety responses which prevent them from asserting themselves in interpersonal situations. The anxiety often generalizes to the therapeutic situation, limiting the client's ability to articulate his concerns and requiring the therapist to pick through a thicket of defenses until the relevant material surfaces. At this point, a questionnaire might be useful as the initial medium of information exchange, to prevent initial hardening of defenses by the client, to facilitate early identification of troublesome life circumstances, and to allow expression of anxiety-laden material without the initial trauma of face-to-face encounter. In short, the questionnaire becomes a stepstone between client and therapist.

Using a questionnaire as an extension of the clinical interview can provide valuable clues about the source and context of the maladaptive anxiety. This author prefers a "broad-gauged" instrument containing questions about a variety of interpersonal situations, both to assist the generality and scope of the anxiety responses and to provide a range of situations in which the client can later begin to practice being assertive. Also, initial impressions are deceptive and what may begin as a well circumscribed area of inappropriate non-assertion may later take the appearance of a broad life-style.

Following assertive training therapy the questionnaire can be readministered, pre- and post test difference scores determined, and objective information obtained about therapeutic gain. Used in the above manner, assertive behavior questionnaires can provide useful clinical information from initial intake procedures, through the execution of assertive training therapy, to an objective assessment of assertive behavior change.

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PROFESSIONAL COLLABORATION: A KEY PROBLEM IN THE IDENTIFICATION AND TREATMENT OF EMOTIONALLY DISTURBED CHILDREN

Jennifer W. Morgan, Ed. D.

Assistant to Director, Medical Education

Dorothea Dix Hospital

Raleigh, N. C.

The problem of inter-agency cooperation and collaboration has long existed between mental health and education and has frequently been discussed in the literature (Dupont, 1969; Harshman, 1969; Hollister, Bentz, Edgerton, Miller & Aponte, 1974; Kessler, 1966; Long, Morse & Newman, 1965). It is the purpose of this paper to therefore offer ways of establishing an effective collaborative relationship between professionals in related fields. Three central concepts to be considered in the establishment of good collaboration seem to be communication, consultation, and coordination.

Communication problems that occur between mental health and the schools usually involve confusion with vocabulary and feedback. Often one agency is not familiar with the jargon of the other and is not aware of what the other is really trying to say concerning a particular child and what the problem is. One thing which is absolutely necessary between the schools and mental health is consistent and good feedback involving detailed observations of how the child is doing and how the family and others are involved. In the schools, there is a problem of the teacher knowing how and what to record and communicate in her reports. With mental health, there is a problem knowing exactly what is helpful for school personnel to know in order to set up a better educational program for the child in the school. Morse, Cutler and Fink (1964) found that teachers of special classes usually ignore the material found in diagnostic reports sent to them by the mental health worker. This might be changed if there was more effective communication between the two professionals so that material could be included in the reports which would be more useful in planning remedial strategies in the school setting.

Another problem is the lack of open communication between professionals. Too frequently one agency will not offer enough information to the other agency. Sometimes this is due to the mounting pressures which they are feeling and sometimes due to basic territorial struggles which exist between professions. It is the responsibility of personnel working in each field to relay information so that it is not secret and esoteric but helpful and in a form which can be used by the other professionals. To deal with and help alleviate these problems of vocabulary, feedback, and openness between mental health and education, there needs to be a great deal of communication between the two professions as to what each other wants and needs from the other.

Difficulties in communication arise during all phases of the working relationship between mental health and the schools. The first most essential steps in working with disturbed children are identification and referral. The school because of their large contact and amount of time with the child must assume the

major responsibility in these two steps. Identification might be thought of as analogous to what the American Cancer Society speaks of when mentioning the seven early warning signs of cancer. The notion is not to say whether the manifestation is in fact cancerous or not but to provide a way to see that early treatment is possible if such signs exist. Identification is at times not easy because behavior that is the product of serious emotional problems is often described in such vague terms as "lazy", "mean", "stupid", or "undisciplined". The root causes of behavior are usually not visible. The teacher and other school personnel must make an initial decision as to whether the behavior represents disturbance or simply a behavior that should be discouraged.

Upon identification of a child who has some of the early warning signs of emotional disturbance, the next step is to assure that the child gets help from the appropriate source (i.e. referral). At this point, good communication between the school system and mental health is vital in order that the problem is understood thoroughly and that the most appropriate type of treatment is prescribed. Communication is not only important during the initial stages but throughout treatment and follow-up. Hollister and Goldston (1965) stated, "The communication that develops between the staffs involved in the screening, referral, diagnostic, placement and interpretation components of the program vitally affects their capacity to mobilize the right resources to meet the needs of the individual children (p. 118)." In order for both sources to help the child and the parents, each one must understand what the other is doing and see that their treatment plans complement one another. The worst type of damage can occur, for instance, if a problem is identified, referred, diagnosed and then dropped.

After the identification and referral process, agencies must consult with each other as to their findings, observations and opinions to jointly devise a good treatment plan for the child. Consultation, therefore becomes a mandatory need which should occur throughout the treatment and follow-up periods. Since mental health works with the total milieu that is involved with the particular case, and takes the major responsibility for the total treatment care of the child, it should be up to them to be available to school personnel such as the teacher, counselor and principal to help them understand and deal with problems concerning the particular child.

Applicable consultation models might be one or more of the four types of mental health consultation proposed by Caplan (1964); especially the "client-centered case consultation" and "consultee-centered case consultation". The latter, and seemingly most appropriate type, presents the consultant's major task as one of evaluating the nature of the consultee's work difficulty with the client and helping the consultee then to remedy the problem. Hollister, Bentz, Edgerton, Miller and Aponte (1974), as a result of a project funded by NIMH, found the consultative relationship between mental health and school personnel passes through two developmental phases, the first being where mental health is called upon to respond to a crisis situation. The second phase is ultimately where mental health staff is used for consultee consultations and helps with not only specific problems but group difficulties, parent reactions, staff relationships, in-service training, and sometimes system-wide problems.

One valuable way that mental health can provide assistance and consultation

to the schools is with in-service training. The teacher, especially, has the most responsibility, the least time and usually the least training of any of the school personnel concerning emotional problems; yet she is the one most often called upon within the context of treatment to provide for the student's involvement in new interpersonal relationships, and to record and observe behavior while also meeting the needs of the other children in her classroom. With the support of the principal, mental health can serve as an educational and training resource to these teachers who do assume such a key role in the early identification and treatment of disturbed children. A model for in-service consultation between the schools and mental health has been proposed by Newman, Bloomberg, Emerson, Keith, Kitchner and Redl (1964) called "Educational Technical Assistance Consultation". This type of consultation is based on the belief that "... on-the-spot, in-service training of a continuous kind needs to be included if teachers, or other school staff, are to be expected to deal with the kind and number of disturbed children with whom they are increasingly confronted (Newman, Bloomberg, Emerson, Keith, Kitchner & Redl, 1965, p. 242)."

The counselor is ideally the one who acts as an interface between the school system and mental health. Many counselors already have the vocabulary to discuss problems with mental health personnel. Additionally, they have training that can be applied in the actual provision of counseling in certain areas. Many have been trained in identification and education techniques which can be applied in the classroom by the teacher working with emotionally disturbed children. Unfortunately, in most school systems the counselors work only at the secondary level, thereby minimizing their utility for early identification and treatment. It is very important, however, for mental health professionals to work closely with the available counselors in the setting up and implementation of treatment plans for emotionally disturbed children as well as in the consultative function.

Coordination, the final concept in the establishment of good collaboration between related professions, must be considered by the schools and mental health during the identification, referral, treatment, and follow-up stages of working with emotionally disturbed children. Coordination becomes especially important when devising treatment plans for the child and his family. Often, if there is not planned coordination of services, one finds a typical pattern of doing and undoing arising where one agency effectively negates what the other is trying to accomplish.

A problem which seems to interfere with the process of coordination relates to organizational relationships and the expectations one agency has for another. Agencies often have unrealistic goals of what the other can and does provide. Mental health frequently has unrealistic expectations of the school system (i.e. only one student per teacher) and frequently the school has unrealistic expectations of mental health (i.e. a magic formula for instant cure). Without effective communication, consultation, and coordination, myths such as these will persist and thus prevent either agency from providing quality treatment for children with problems.

In summary, for there to be good and effective collaboration between mental health and education professionals, there must be good communication, consultation, and coordination. These principles can also be applied to other professions

and agencies who are working to help the same population or who are working towards a common goal. Such an example might be the various specialties within the mental health profession which constantly need to collaborate. Better communication, consultation, and coordination would therefore hopefully lead not only to better inter-agency cooperation but to better intra-agency and to better inter-personal cooperation.

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DEALING WITH FLUCTUATING EGO STATES IN BORDERLINE PSYCHOTIC CHILDREN:

A Case History of a Seven-Year-Old Boy

Manuel B. Versola, M.D.

Thomas M. Haizlip, M.D.

Child Psychiatry Residency Training Program

Dorothea Dix Hospital

Raleigh, North Carolina

Introduction:

Ekstein and Wallerstein (1956), in their classic paper on psychotherapy with borderline psychotic children, have described these children as demonstrating tenuous ego boundaries resulting in observable fluctuations in ego states throughout the treatment process. Clinical material drawn from treatment of borderline children often shows dramatic shifts from conventional, chronologically appropriate behavior in the therapy hour to regressive psychotic episodes which may then be rapidly replaced by the appearance of pseudoneurotic defenses.

The following case presentation illustrates the fluctuations of a borderline psychotic child's ego states, the vivid intrapsychic organization, the therapist's responses to and interpretations of this child's unique, creative productions and behavior during play therapy, and the subsequent development of more adequate defense mechanism and higher levels of ego functioning.

Case History Summary:

Bill was a seven year old boy referred for treatment by his guardians, who were concerned over his pervasive fearfulness and poor self-esteem. Social history information on developmental milestones was sketchy but revealed markedly chaotic, violent, and unpredictable parental behavior during Bill's first four years of life with his biological parents.

Bill's diagnostic evaluation revealed a depressed, highly anxious child whose chaotic, unpredictable environment and lack of adequate gratification of early dependency needs had resulted in the disturbances in object relationships and ability to synthesize stimuli typically seen in borderline psychotic children.

Treatment Process:

The patient has been seen in one-hour weekly sessions for eight months, with treatment goals focused on developing a more adequate identification process through the therapeutic relationships and the emergence of improved secondary process functions through interpretations geared to the current, fluctuating ego state demonstrated in play therapy sessions.

In the initial treatment sessions Bill had to first be reassured that his guardian was in the next room before he was able to enjoyably enter into puppet play which he "directed", dealing with themes of death, sickness, and destruction. The hour ended after the "doctor" puppet assigned to the therapist asked his own "crow" puppet what his problems were, and the doctor puppet was instructed to respond that he would do his best to help the crow.

In the next seven sessions he worked through much of the anxiety surrounding his treatment by denial, projection, and counterphobic maneuvers. He did not

respond to the therapist's interpretations that his puppet play might represent fears of losing meaningful people in his life and typically responded with "I don't know" when questioned about his feelings.

In the ninth session, faced with the stress of a weekend trip planned by the family, Bill began to use play doh in regressive fantasy play. He constructed a breastlike object and an intricate landscape with a network of highways surrounded by forest fires. He asked the therapist to construct more difficult figures as he described them, including a dinosaur with eggs and a kangaroo with a baby in the pouch. Through this maze of highways and objects he moved a car, lost and out of control, which was finally able to be saved after making a telephone call for help. A green outer space monster began shooting at the passing car, continuing the play's themes of destruction, abandonment, and unmet needs for protection and nurturance. Interpreting within the regressive metaphor and "ego lending," the therapist successfully stopped the monster by reasoning with him. Bill literally compartmentalized the fears and anxieties reflected in his fantasy play by storing the play doh landscape and figures in the therapist's desk drawer, to which he returned intermittently from session to session.

In the eleventh session he discussed in some detail a fire in his school classroom and a fire he had started in his home, turning finally to the play doh materials and adding more structure to the fantasy planet. The green monster no longer shot at passing cars but now had little monsters seated around a bonfire while he taught things like the danger of playing with fire. While destructive impulses were projected in this play, they were near conscious awareness and he was able to accept and recognize the resemblance, pointed out by the therapist, of these play incidents to the actual firesetting as well as his own wish to control his destructive impulses.

The next session fell before an announced two-week interruption during the therapist's two-week absence. Bill's planet was inhabited by a doctor, a "man" and his assistant who saved the planet from raging fires started by the monster. The ghost drove the doctor away and took his place, finally hanging the doctor, dripping blood, over his grave. The murderous, destructive fantasies stirred by the therapist's perceived abandonment were barely controlled, and the therapist gave only minimal interpretation of the play. When therapy resumed he created a machine which made people come alive again and regenerated the doctor and people killed in the monster's conflagration.

Therapy was again discontinued for two weeks during Christmas, and the patient reacted by having monsters blast the doctor with an atomic bomb and hung him over his grave where his dripping blood caught fire. When therapy resumed after a pleasant vacation spent in outdoor task with the guardian, he recounted some of the pleasures they had enjoyed and played with Lincoln logs, constructing a jail for bad parents around which their children played happily for hundreds of years, never growing up. While the play reflected some fears of independence and needs for nurturance, the play material showed a generally higher ego state. Returning in his play to the play doh planet, elaborate walls were built around the building housing the doctor and his machines. A robot revived the doctor, then both revived the other previous victims through the special machine. The ghost who replaced the doctor became the assistant, and the robot guarded the build-

ing where the doctor cared for a boy's cut knee, using a special chair attached to a machine to prevent pain. Identification with the therapist is symbolized by the doctor, and the walls he began to construct represent the compartmentalization of his primitive Id impulses. This walling off and encapsulating of threatening, dangerous impulses allowed destructive impulses to emerge in later sessions, to be dealt with by neurotic ego states.

When his sister was also admitted to the clinic for therapy, Bill handled his feelings of sibling rivalry in a more neurotic manner, playing out his concerns in the metaphor of Goldilocks and the three bears. Symbolic of the repression of the psychotic material, Bill built the second level, keeping the first level of the play doh planet in the drawer only to glance on it once in a while. Subsequently, the three bears were punished by the "Six Million Dollar Man" for frightening Goldilocks away. This material seems to represent the emergence of an archaic superego. The therapist was able to help Bill recognize the punitiveness of this superego and to better deal with the feelings of his sister coming to the clinic. Consequently, Bill was able to utilize more neurotic defenses.

In summary, seven year old Bill, a borderline psychotic child, presented fluctuating ego states in play therapy sessions, utilizing regressive fantasy play to deal with environmental stress and conflict from destructive impulses approaching conscious levels. The therapist's responses were primarily within the context of the regression with occasional interpretations of the symbolic meaning of the play productions. Elaboration on the meaning and intent of the metaphors used in mature secondary process language which links content directly to the conflict was avoided. This allowed Bill to work at his current level of intact ego functioning until he could develop strengths and defenses for moving to a more mature level of functioning.

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THE MARATHON GROUP: ITS ORIGIN, DEVELOPMENT AS A TOOL OF PSYCHOTHERAPY AND ITS LIMITATIONS

Landrum S. Tucker, Jr., M.D.
Department of Psychiatry
University of North Carolina
Chapel Hill, North Carolina

It is in the nature of things that primates live in groups. They are comfortable eating together, sleeping together, looking out for one another, and giving pleasure to one another. Observation of nonhuman primates has led investigators such as Washburn and Devore (1961) to conclude that group behavior ". . . is one of the species' principal adaptations for survival. Most of a baboon's life is spent within a few feet of other baboons . . . for a baboon life in the troop is the only way of life that is feasible."

Few would disagree that it is quite appropriate to substitute in the above statement the word "man" for baboon. We humans are social animals to the utmost. Our society is a great complexity of groups within groups. There is marked variety in ethnic group characteristics regarding customs of sexual behavior, bodily costuming, "grooming" practices, mobility, aggression and dominance and so on.

To provide for division of labor, execution of vital functions, and maximization of pleasant states man has formed specialized groups within the larger societal groups. Human beings raise their children and nourish themselves in one subgroup, work and play in another subgroup, think and meditate in still another subgroup, etc.

Many of these sub-groups keep the same identity regardless of the constituency; that is, in political, religious, educational or economic sub-groups the behavior of human beings is ritualized. Individuals behave one way in one group but alter their behavior markedly in another sub-group. Ritualized groups have taken on powers that are overwhelming to individual human beings; so much so that the latter relinquish possessions, pleasures, loved ones, even life itself if the group demands it.

But, as with the nonhuman primates, human groups have individuals who are selected to serve as leaders. Freud (1921) discussed the profound influence of the group leaders and the group "opinion" upon individual members in his monograph *Group Psychology and the Analysis of the Ego*.

He asserted that the essence of conscience is "social anxiety," the fear of public opinion. Developmentally this follows the censoring influence of parental figures upon their children in the very basic subgroup, the family.

The masterful, self-confident, independent leader is psychologically different from the other group members. He is narcissistic in his emotional needs and, according to Freud, he represents that which the members wish to attain; he becomes their Ego ideal. Strong leaders can cause group members to renounce the internalized parental image (their own conscious) and relegate its role to the leader.

There is an ominous quality to the words of Freud, a warning of the hypnotic influence of group pressure upon the personality of the individual. He refers to the

earlier writing of Le Bon (1885) and his thesis that as a part of a group man regresses to a "primitive mental state." Emotionalism, suggestibility, aggression and barbarism replace rationality, control and critical faculties.

The survival value of the "group" for man must constantly be weighed against its destructive, regressive impact. The internalized ego controls and independent self esteem and pride of the individual, considered as a step up the evolutionary ladder, must be weighed against the loneliness and isolation man feels apart from his fellow human beings.

Psychoanalysis and individual psychotherapy have offered man a unique way to gain self-understanding and self-knowledge—a way to heal his mind. But there also has existed a need for man to gain understanding and knowledge of himself as a group member.

In the late 1920's it was found that individuals who had withdrawn from societal groups because of mental illness or problems of living could be brought back into society again by first forming a group amongst themselves with a non-ritualized, non-narcissistic person serving as their leader. These patient-groups were different from the usual societal groups in that members could be less afraid of the "group;" i.e., there was no order of events, no expected competition, no intimidation by or demand to please the leader; members could say virtually anything they wished to each other and there was a leader whose primary interest was to promote interpersonal and individual awareness.

Moreno was one of the earliest enthusiasts of group treatment; he encouraged patients to change roles with one another, to take on roles of significant others and to enact dilemmas which were causing anxiety in the external community or family sub-group. Some of the fear of the ritualized sub-groups was dissipated and insight obtained in this "psychodrama" approach. Moreno edited the first symposium of group treatment in 1945.

Some ten years later a young therapist was to publish a book which would expand upon Moreno's enthusiasm for the therapeutic value of the emotional reenactment of human problems.

George Bach who, like Moreno, was raised to manhood in Western Europe, left Germany in 1936 at the age of 22. His country was succumbing to the very phenomenon of which Le Bon and Freud had warned—his fellow citizens had, it seemed, regressed to a "primitive mental state" under the reign of National Socialism and "The Leader." Perhaps understandably, Bach became very interested in group dynamics and group communication. He received his PhD in psychology from the University of Iowa in 1944 and in 1954 he authored the book *Intensive Group Psychotherapy*, now a classic text for would-be group therapists.

The adjective "intensive" was of some significance because Bach was beginning to believe that the traditional non-directive approach of psychoanalytic psychotherapy was not the best means of promoting group interaction. That is, "intensive" was meant by Bach to describe the emotive quality of the interaction between patients and also between them and the therapist.

Following the scheduling model of individual psychotherapeutic hours, Bach's original group treatment sessions usually were held from one to two times a week and were 1 or 2 hours in duration. He used this schedule for several years but

was continually discouraged with how long it took patients to relax with each other, to let down their ritualistic masks and to become genuine individuals within the group. He began to wonder if another, more effective, more efficient method of successful group treatment might not be found.

In 1963, Bach learned of all day group sessions with psychiatric inpatients conducted by Wickland and Stoller. He communicated with Stoller and they collaborated in holding experimental weekend group encounters with outpatients and they were impressed with the results.

In 1964, Bach presented an account of this new approach to the meeting of the American Psychiatric Association and he originated the term "marathon group treatment."

Bach (1966) described his observations based on over "1200 therapeutic hours" that "for many patients . . . the 1 or 2 hours sessions . . ." were not sufficient in time for them ". . . to take off their social masks." More time was needed if people were to stop playing games. Bach claimed his clinical experience to have been that people responded to prolonged group pressure in terms of dropping manipulative and impression making behavior and became honest and spontaneous with one another. Indeed, he went so far as to assert that group pressure is the major vehicle in producing behavioral change as opposed to the therapist's individual interventions and interpretations. Bach then argued that the whole constellation of becoming transparent, leveling with one another, attempting change and practicing new behavior is a "natural gestalt," a unit of experience which was best not broken up ". . . but should occur as a whole. . ."

His first description of the Marathon encounter was as follows:

"The actual schedule . . . varies, depending on the setting and . . . goals and values. Members meet non-stop throughout the first night . . . for 24 hours or longer. The Marathon terminates in non-verbal, silent communication exercises, conducted in pairs. This is followed by a closure party in which sub-grouping is resumed."

Bach went on to say that his participants were involved in regular group therapy first and that the Marathon was interspersed at intervals of three to six months. There was some specializing of the Marathons, e.g., marital couples, business executives, group leaders-to-be, social science researchers, etc.

Participants were screened not as to psychiatric diagnosis but as to attitudes toward self-change and group constellation. There must have been a prior indication of wanting to change in the participants. Usually participants were beyond the game of psychiatry;—"I'm sick, YOU cure me!"

Every participant was expected to take a therapeutic role. Regressive dependency on the group was discouraged. "Constructive aggression" was encouraged. The fatigue produced by the Marathon encouraged truthfulness. "Tired people do not have the energy to play games."

Bach ended this first presentation of the concept of the Marathon group by outlining ten basic ground rules which ". . . may or may not be explicitly spelled out depending on the particular subjects involved."

The Ten Marathon Commandments:

- (1) To stay together in the same place and not leave until the group breaks or ends at its prearranged time.
- (2) Creature comforts are to be taken care of on a self-regulatory basis. There will be no alcohol or drugs taken during the Marathon proper.
- (3) The group leader is bound by the same rules as everyone else, except that in order to keep his services alert he has the privilege, during every twenty-four hours of work, to rest up to four hours away from the group. The group continues in his absence on a self-regulatory basis.
- (4) All forms of physical assault or threats of physical violence are outlawed.
- (5) Legitimate, professionally correct group procedures such as Psychodrama, Awareness-expansion exercises, "Sensitivity Training," Transactional Games Analyses, etc., may be used temporarily during a Marathon, but only under very special circumstances . . . the use of a "technique" may retard . . . the emergence of trust, transparency, and intimacy.
- (6) The encountering experience is a four-phase process. Individual expressions are (a) reacted to, and (b) these reactions are shared in a "feedback" (c) The "feedback" in turn generates counter-reactions (d) from the original expressors as well as from the rest of the group.
- (7) "SHOW ME NOW . . . DO NOT TELL ME WHEN" is the Marathon Leitmotif. Owning up to feelings *here and now* and sharing them is the mode of participation.
- (8) "AS YOU ARE IN THE GROUP, SO YOU ARE IN THE WORLD." In the long hours of a Marathon one cannot help being seen for what he really is and to see what he may become.
- (9) Group members' changes and improvements in participation will be attended to by the group. Giving affectionate recognition to growth and new learning is as much in order as cuddling, defensive behavior is out of order.
- (10) While nothing is sacred within the group, the information gained during a Marathon weekend is confidential in the nature of professionally privileged communication.

In 1967, three years after this first presentation of the Marathon group concept, Bach published one article on "Group and Leader Phobias in Marathon Groups," and three articles on Marathon group dynamics dealing with (1) the professional group facilitator, (2) dimensions of helpfulness, especially therapeutic aggression and (3) disjunctive or non-therapeutic contacts.

In the first article Bach stresses that the group leader is a model person for the group, i.e., he transparently shows his feelings and interests as he expects the group to do. The leader is responsible to keep alive ". . . sober, brutally frank, candid feedback, for this is the number one value of the marathon group culture. Genuine human contacts are intrinsically healing . . . the phony . . . is evil and

destructive." Bach did an experiment using two groups without an "expert" leader for 20 of the 24 hours, and another two groups which had two expert leaders each for the whole time.

The leader-led groups were more aggressive, argumentative, demanding, outspoken, tactless and tough, and 73% of the patients reported significant improvement in communication while 58% reported such improvement in the leader-poor groups. Bach concluded that the expert-rich groups came out ahead but said that "... we must ... acknowledge ... the expert group leader was at times seen as not only superfluous but even as occasionally clearly disruptive of ongoing, group-healing processes."^{1,2}

In his analysis of group dynamics in a second paper Bach (1967) again described the Marathon, but new concepts were added. The participants were depicted as "... usually *not* emotionally disturbed, psychiatrically sick persons who are desperately seeking ... help. Rather the ... experience appeals to healthy, growth-seeking individuals who sense ... th need to have more authentic interactional experience."³

In professionally conducted groups, participants are screened and, if accepted, "prepared for the experience." Those with excessive anxiety are urged to enter regular groups first. Also "warm up" groups are conducted for pre-registrants in which basic rules are discussed and irrational expectations corrected.⁴

While in the United States Air Force I had the good fortune to meet Captain John Breeskin, a very interesting and experienced group therapist. At RAF Lakenheath in England Breeskin conducted the first Marathon in a military setting. This was in 1968. He selected 15 participants who had had an average of 20 regular group hours prior to the Marathon. There were 6 married couples and 3 participants who came without their spouses. The group was heterogenous as to rank, sex, age, and education. The Marathon lasted for 24 hours with one break for food.

Breeskin stated that 67% of the participants found the encounter helpful just after termination whereas the figure dropped to 40% six weeks later. On the other hand 80% wanted to repeat the experience just after and, six weeks later, 100% wanted to be in another Marathon. Aggressive confrontation was the highest dimension marked for "help given" (47%) while self understanding was the highest dimension in which help was received (60%). All subjects continued in ongoing weekly group and/or marital therapy after the Marathon. There were no casualties.

1 The negative aspect of the "expert" would be consistent with the distaste more mature individuals might feel for the Narcissistic, omnipotent leader-type Freud described.

2 This last conclusion could also be construed as supporting leaderless or amateur Marathons; but in his first discussion of Marathon group dynamics Bach described the destructive effects do-it-yourself or "wild" Marathons. This will be reconsidered when the various criticisms of the Marathon encounter are discussed.

3 This redefinition of the participants as preferably being healthy individuals is somewhat confusing in that it necessitates the question, "What does it mean, a therapy for health people, and not for sick people?" This new direction is quite different from Stoller's original all day therapy groups of (very sick?) psychiatric inpatients. Indeed, making the Marathon into a "ritualized" group for expanding self-awareness of health people may be contradictory to the original therapeutic potential of the non-ritualized group. On the other hand this is most likely a semantic issue since any sophisticated, individual therapist would readily state that the best outpatient candidate is the one who is steadily employed, reliable, and eager to take an active role in solving his problems—in essence, a "healthy patient."

4 The point is made for the first time by Bach that intensive, prolonged encounter may be harmful to certain individuals. The danger of the group's powerful capacity to disrupt the individual's internalized ego systems as described by Freud is brought to mind.

In 1969 I was working as a general medical officer at a small Air Force base near RAF Lakenheath. I was interested in group psychotherapy and, after consulting with Dr. Breeskin, I decided to start a weekly therapeutic group. I selected members from the patient population of 7000 on a voluntary basis. After eight months of weekly 1½ hour sessions, I proposed a modified marathon encounter to the group as a "termination session." Most of the members showed interest and one month later a twelve hour "minithon" was held.

Of my 8 original group members three did not attend the minithon. The participants were as in table one.

St. and C. had come to the regular group for the 2 or 3 sessions prior to the minithon and most of the group had encouraged them and accepted them into the minithon. St., a friend of D., had brought her husband L. to the minithon on the urging of the group. L. had no previous group experience.

The minithon encounter went as follows. The newest and quite unknown member, L., was tested by T. in the first two hours. T. exposed a history of homosexual experiences and then became very angry when L. said he had "only come to listen." This was handled by supporting L.'s courage in participating in something with which he had no previous experience; L. then opened up to the group, acknowledging that he wanted to take an active part and was accepted. C.'s relationship with her husband and then all men was the next focus of attention. Her interactions with the group males was looked at; her concepts of love, the male "stereotype" and her need to be conquered were explored and she responded vigorously and later insightfully to the confrontations made. St.'s sexual relationship with L. was explored and their uncertainties about perversions, especially masturbation, were discussed and detoxified by the group. The final hour was spent discussing the pros and cons of the total group experience; all members felt it had been helpful.

It was evident at the termination that the newest members had received the most aggressive confrontation in the minithon, and the more experienced but previously "sicker" members had served as the therapeutic aggressors.

I had the opportunity to follow the participants through the following year. J. the 21 year old sergeant left 2 months after the encounter to return to Florida. He was noticeably more mature and insightful. He had accepted himself and his wife, and their sex relationship was free from guilt and satisfactory to both. He had dealt with his homosexual fears based partly on a memory of fellatio with a cousin and also his guilt over the accidental death of this cousin. J., a very shy, withdrawn, depressed young man when I first encountered him, had gained remarkable ego strength by the time he left and had helped others appreciably.

T. learned how to get along with those whom he worked and how to handle petty sarcasms and criticisms. A very verbal and intellectual man he trusted the group and exposed his complete inability to spell the simplest word. He gained self esteem and was able, for the first time, to offer help to others, concern for others outside himself. T. had no psychosomatic outpatient visits or psychiatric referrals during the next year. I was left with warm feelings for both J. and T.

D. was not seen again in the outpatient clinic after termination of the group. Previous to the group she had been seen at least once or twice a week. She went

	<i>Name</i>	<i>Sex</i>	<i>Age</i>	<i>Rank or Status</i>	<i>Problem</i>	<i>History of Therapy Prior to Beginning with Me</i>
Original Members	J	M	21	Sergeant (White Southern)	depression, conversion	psychiatric hospitalization 2 weeks, individual therapy 3 months
	D	F	27	Wife/career tech Sgt. (White Southern)	headaches, backache, heavy alcohol use	no previous psychiatric therapy
	T	M	28	Sergeant (Black raised in orphanage, reform school)	passive, aggressive, inadequate, poor progression in rank	18 months individual therapy
	B	M	29	Captain (Jewish, raised Chicago)	rigid, inflexible introverted	12 months group therapy with wife marathon x 1
Later Members	G	F	27	Wife/captain (White Prot. midwest)	anxiety, depression, orgasmic dysfunction	18 months individual therapy 12 months group therapy, 1 month psychiatric hospitalization, marathon x 1
	ST.	F	26	Wife/Staff Sgt. from Greece (Greek Orth)	marital and sexual dissatisfaction	no previous psychiatric therapy
	L	M	28	Staff/Sgt. Italian N. Y. husband of St.	marital problem	no previous psychiatric therapy
	C	F	23	Wife/Staff Sgt. (White from Western USA)	headaches, excess fatigue	no previous psychiatric therapy

off all tranquilizers and analgesics. She enjoyed sex with her husband; she became a happy, smiling likeable person.

G., the wife of the captain required supportive outpatient visits two or three times a month during the next year. She was able to deal with the knowledge of her husband's assignment to Vietnam and relied less and less on tranquilizers. She enjoyed sex more and more and became pregnant before the year was over.

B., the captain, was able to be more assertive and aggressive. He continued to be good at his job and did not seek any additional psychotherapy.

C., the 23 year old housewife, may have benefited most from the 12 hour encounter. She was not seen again in the outpatient clinic and she became pregnant during the year. She seemed pleased with the pregnancy and satisfied with herself.

Like C. I felt that the newcomers, St. and L. benefited more than the original group members from the prolonged encounter. There was no further request for marital counseling or psychiatric help, and they seemed satisfied with their marriage.

Critics of the Marathon have tended to lump it in with shorter group interactions and to label the whole lot, "Sensitivity groups, T-groups, or Encounter groups." The main objective of these groups has been given in so many words as the promotion of an emotional catharsis; the free expression of pent-up hostilities, frustrations, sexual feelings, etc., in a permissive group environment.

Criticisms have had to do with the shallowness and theatrical quality of such emotional expression, the morally questionable encouragement of sexual and aggressive acting out on troubled people, the lack of truly professional and capable leadership in many cases and the documented emotional damage—in some cases psychoses—that have been reported.

Jaffe and Scherl presented two cases of psychoisis related to T-group experiences in 1969. One case resulted from a two week, one brief session a day, routine and the other from a more typical weekend Marathon-like encounter. The authors reviewed the antecedent circumstances and the procedures of the casualty-producing groups and recommended strictly voluntary participation of subjects, the definition of T-groups as "non-therapeutic," i.e., not for the psychiatrically ill, strict limitation of physical contact, and followup evaluation of participants.

Kane, Wallace and Lipton (1971) used the guidelines of Jaffe and Scherl to help define in what areas casualty producing encounter groups might be delinquent or deficient. Marathons were not separated out as a statistical category; they were seen as "more unremittingly intense" encounter groups breaking down defenses with fatigue.

North Carolina psychiatrists were polled on the number of T-group casualties they had seen in 1970 and approximately 31% had seen a total of 91 casualties. Startling statistics revealed that 80% of the casualties had not been screened for participation, 70% had not understood what limits the experience had, 65% had no followup and only 24% had attended groups led by health professionals.⁵

Bach, the opener of Pandora's box, had criticized the non-professional Marathon as either allowing "non-creative" explosive of hostilities (causing panic in the

⁵ Psychologists 20% and psychiatrists 4%.

group and some members to fear "flipping out") or as being too mild, defensive and phony with too much pseudo-loving.

Perhaps then, the main corrective measure would be to tighten down on leadership, to outlaw amateur encounters and to allow only highly trained or well supervised therapists to act as leaders. Certainly this should be done. However, Yalom (1971) recently has reported on 169 student participants in all kinds of encounter groups led by experienced therapists. There was well-informed preparation and strict followup. Of these 169 participants, seventeen were classed as casualties—subjects with bad psychological after-effects. Indeed, three subjects became psychotic or severely depressed. Even more disconcerting was the statement that the more self-assured, aggressive, charismatic, leader produced the most casualties. Also, the "stimulating, exciting" leader had the poorest long term beneficial results. The low-keyed, more unstructured, more "boring to watch" leader produced the best long term results with the fewest casualties.

Yalom's results of carefully controlled and followed professional group encounters are a significant warning to overzealous therapists and serve to humanize the heroic imperatives of Bach. The latter comes across as charismatic in his pronouncements with bold directives and much self confidence. I would feel more comfortable if he had mentioned just a few failures. But I respect Bach's insight into the need for people to unmask themselves, to gain intimacy and the therapeutic value of aggressive confrontation for those who are too nice and phony. One can't help but speculate on how his early life experiences in Germany amidst a population of nice, law abiding people politely following the National Socialists to slaughter might have motivated Bach to demand genuineness and truth as psychological necessities for a healthy societal group.

The poorly conceived "sensitivity groups" described in North Carolina and undoubtedly existing many other places are unfortunate—quick cure-alls for man's loneliness—perhaps substituting what Yalom terms "pseudointimacy" for real intimacy.

My own experience gave me the feeling that the healthier subject could safely use a single marathon encounter to gain some help in problem-solving and self-awareness, but real "intimacy" requires more long term involvement. The not-so-healthy subject requires primary work in a regular analytically or interactionally oriented group, but he probably would make gains with the same group of patients—already comfortable with each other—in a prolonged group interaction later on.

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WAYS OF WORKING WITH MOTHERS OF YOUNG CHILDREN AS A MEANS TOWARDS EARLY DETECTION AND SHORT INTER- VENTION IN REGARD TO EMOTIONAL DISTURBANCES

Ruth Oppenheimer, Child Analyst
Department of Child Psychiatry
Sheppard and Enoch Pratt Hospital
Baltimore, Maryland

Working in Child Guidance Clinics we are always faced with the frustration of being inundated with too large a number of disturbed children of school age. In fact, there are always more than the limited number of staff is able to treat. Our frustration is compounded by our knowledge that each of the disturbances has a long development behind it and that their antecedents started in the earliest years of life.

Work with the parents of these children makes us realize that often they have felt insecure in regard to the upbringing of their children during their early years. For various reasons they have not been able to consult anybody in regard to what to expect from their young child and how to handle his emotional needs.

This paper deals with thoughts of how help of this kind could be supplied to parents of young children with the hope that children who show difficulties early—and most of them do at one time or another—could be helped by their own parents if the disturbance is of transitory nature. Should there be a more permanent disturbance then it could be detected early and receive short-term intervention rather than a lengthy period of treatment when the child is older.

This paper is divided into three parts. The first part deals with a consideration of the normal development of the child during the first six years of life, and to what extent this has a bearing on later emotional disturbances. Part II discusses how parents are being helped by workers in health care and education at present and how workers in child psychiatry could aid these professionals in this work. Part III proposes a plan by which more help could be given to mothers of young children in a Child Guidance Clinic setting.

I

When the first patients were treated by psychoanalysis at the beginning of this century, and when it was realized that each neurotic conflict has its starting point in early childhood, it was hoped that the new knowledge about what it is that creates these conflicts could lead to child rearing practices that could avoid these pitfalls.

However, it was soon found that it was not possible to raise any child without creating conflicts. Child rearing itself means helping the child to become a part of the society he lives in and, as we well know, society in general and the culture we live in particular makes demands on the child to adapt himself to it (See: Anna Freud: *Normality & Pathology in Childhood*). Examples of this are weaning, toilet training, beginning of nursery school. Other areas in which most children experience conflicts occur in regard to separations from love objects and from the birth of a sibling, i.e. situations which cannot be avoided and are bound to be stressful for the child. In addition to these conflicts created from the outside,

there are internal conflicts which are the product of normal growth and development (i.e. castration anxieties, oedipal conflicts.)

The question arises: If we cannot avoid conflict, how then can we help the child to grow up without becoming emotionally disturbed? The answer is that the child can be helped by the people in his environment to develop a strong ego which will help him to deal with conflicts whether they are conflicts with the external world or have become internalized. A strong ego is the outcome of good early care and a good mother-child relationship, which provides the infant with a feeling of security and trust.

In order to achieve this kind of mother-child relationship certain requirements are essential, both from the side of the mother and that of the infant. The infant needs to have basically normal physical and sensory equipment (we all know how certain sensory deficits in infants can upset mothers). Also needed by the infant is a relative freedom from trauma and undue environmental stress.

On the part of the mother we need a fairly healthy, well-adjusted personality whose own psychological needs do not affect her handling of the infant. She needs an ability to be turned in to her child's needs and to be able to consider his specific needs as a specific individual. She has to have a knowledge of the emotional development of infants and a need to know how, for example, separations and hospitalizations effect a child. She also needs to know ways and means in which she can help a child in other situations. This in turn will give her the confidence to deal with it and to provide the infant with a good auxiliary ego. In addition the mother needs an ability to verbalize feelings for her child to explain to him what he needs to know and why she has to make certain demands on him. Provided the basic relationship between mother and child is one of mutual trust the child will be able to accept certain demands his mother makes on him as he grows older.

Of greatest importance is for the mother to know at what time and to what extent she can stop acting as an auxiliary ego for the child and can begin to let him function autonomously in any one area. Provided she has been well tuned in to his needs from the beginning she has become able to relinquish her acting for him and in small doses has increased her expectations of him. This has resulted in the child having learned to experience some of the less pleasurable aspects of life and he has learned to deal with them by the use of newly acquired tools.

He has learned ways of adapting himself to the demands which in the first place came from his mother. Locomotion, thinking and verbalization are some of these tools and gradually he learns certain defense mechanisms which allow him to come to terms with unpleasurable feelings from inside himself and help to give him a feeling of mastery of unpleasant realities. A child needs a good balance between guidance from his environment and an ability to do things for himself and to master situations. The balance shifts during childhood and in a harmonious mother-child relationship the transition from mother acting as an auxiliary ego at birth to the achievement of autonomy of the ego on the part of the child is very gradual and in accordance to the needs of both mother and child, who during this time period have become adapted to one another.

I have painted here the most ideal picture of emotional growth during the

early years, and usually somewhere along this line of development we encounter conflicts and difficulties. However, it is my firm belief that mothers could be helped with these, if they realized how important the early solutions of these difficulties are, and if they had places where they could turn to discuss developmental difficulties and conflicts and could share them with a more objective professional. If the child during his pre-school years has developed an ego which is able to master difficulties and has developed a relationship of trust with his parents and based on this, with other adults, he should be able to function well and enter a fairly conflict-free latency period.

II

The second part of the paper deals with ways and means in which workers from the field of child psychiatry are and have been working with professionals concerned with child health care and education and where they hopefully can help them to improve their skills still further, so that these workers with children can help mothers with the emotional care for their children.

a. *Work with Pediatricians.* More and more child psychiatrists, analysts and psychologists have come to spend time consulting with pediatricians on questions of emotional development. Many pediatricians spend some time of their training in a department of Child Psychiatry. Unfortunately, at present, these places are again mostly concerned with children of latency or adolescent age, and the time pediatricians can spend there is usually not long enough to get very much experience of working on early mother-child interaction. However, connections between later emotional disturbance of a child and early aspects of disturbance between mother and child can be traced and convince the pediatrician of the importance of work in this field.

Through consultations with psychiatrists the pediatrician has become more aware of the child's emotional development and he imparts his knowledge and observations to the mothers and encourages them to share their observations of the infants with him. Pediatricians have also become more aware of what illness, doctor's visits and hospitalizations mean to a young child and how they can avoid or lessen the traumatic effects of these on the child by good preparation of child and mother. The pediatrician can help the mother to prepare the child by going over the imminent procedure with her, making sure that she is able to bring out all her doubts and fantasies about it. Once this is done successfully she can allow the child to bring out his feelings and can help him deal with the imminent procedure in a realistic manner.

In the same way the pediatrician can help the mother to help the child with difficulties in other spheres. It will help the child not to get overwhelmed by anxieties and will enable his ego to master the unpleasant experience.

b. *Work with Nurses in Well-Baby Clinics* is another area where workers from the field of child psychiatry could give training to nurses to work with mothers in regard to the emotional well being of the child. As far as I know, this has not been undertaken on a large scale. Most of the Well-Baby Clinics are not well enough staffed to give more than physical care to young infants. The emphasis is on the baby getting the necessary immunizations and regular visits to the clinics become less frequent during the second year of life and usually stop by the time

the child reaches the third year. Moreover, it is usually the mother from the lower socio-economic level who comes to the Clinic rather than to the pediatrician, and so far I have found that she tends to come to the Clinic when the child is sick or hurt, and does not see the need for regular visits when the child is well. Much work could be done by us in conjunction with a Well-Baby Clinic, where the mothers could be shown by an interested nurse that regular visits in order to discuss emotional and physical development could be of much help to them. The first step in this plan would be training of the clinic nurses in matters of emotional development and mother-child relationship. Each mother would need to be given enough time to develop the kind of relationship with the nurse so that she would be willing to share this aspect of development.

It would be important for the nurse to have psychiatric consultation for work of this kind to help her become aware of some of the difficulties mothers have in realizing where a "blind spot" in their own emotional life prevents them from seeing what is going on in the infant. I feel that in Well-Baby Clinics there is a large yet untapped source where Child Psychiatry could make inroads toward earlier detection of emotional disturbance and possibly short-term treatment could be provided for these.

c. *Consultations with Nursery School Teachers* have been given in many nursery schools over the last years. Teachers of young children are well aware of the emotional experiences of their charges and are usually very willing to discuss these with their mothers. Many mothers have become more aware and observant of their children's emotional life as a result of these discussions.

One difficulty I have often encountered in working with nursery school teachers is their tendency to identify with the child and quickness in blaming the mother for a presenting difficulty. However, they are eager to help the child and motivated to consult with us, and we can help them to look at the mothers and their needs in a more objective way. In spite of a more growing concern to look towards prevention and early recognition of emotional disturbance, and thoughts that are being given to the additional training for pediatricians, nurses and nursery school teachers not enough referrals of young children reach Child Guidance Clinics.

This is very regrettable because many a time a disturbance in a pre-school child is still transitory and could be treated in a much shorter time. Much of what has become unconscious by the time a child is of school age is still much more easily available in the young child. Conflicts which are still to the largest extent between the young child and the external world have become internalized and unconscious by the time the child is six years old.

III

These considerations have led me to think of a plan which I would like to present as the last part of this paper. I think it would be more efficient and in the long run of economical advantage if Child Guidance Clinics could have a consultation service for parents of young children as an inherent part. It is envisaged that parents could attend at regular intervals to discuss all their children of pre-school age, either individually or in groups. Our main aim would be to help the mother achieve the best possible development of the mother-child relationship I

have described above. The mothers we meet are not all healthy, happy and well adjusted and we cannot expect that they will be so through our contacts. But we can help them to become aware of their own needs, so that these would not have to enter into the relationship with the child. If this could be done she would become better tuned in to her child's needs. Knowledge of the emotional development of infants could be imparted to a mother, but not by giving her books to read, but by talking to her about her own child and by discussing what she experiences in relation to him.

Verbalization between her and the child could be encouraged in such talks. It is very helpful to talk to a mother about something she has to discuss with her child; whether it is preparation for a visit to the doctor, or for the birth of a new sibling or giving information on sexual matters in response to the child's questions, in very simple terms, similar to those she can use with her child. In work of this kind it would be the task of the worker in the clinic to assess the degree of the mother's being tuned in to the child. Special attention should be paid to distortions or "blind spots". One should ask oneself, how the mother might feel about the area she has come to discuss. What thoughts might she have had on how to approach the task? It is important *not* to give direct advice, but to let the mother, herself work out a way of approach. If her approach was such that we would feel it would not lead to a good solution, we would have to consider whether given her and her particular child, this approach might not have certain advantages. Is she aware of her own feelings in regard to this area, or are there difficulties in her own life which may have interfered with her awareness of her child's feelings?

When we reach cases like this it is difficult to differentiate at what point we have left the area of prevention and entered the field of intervention. But, hopefully, the intervention would be of shorter duration than at a later stage. We would have in our favor a detailed developmental history and good knowledge of the background, which often take a long time to acquire when an older child gets into treatment.

There are at present various obstacles to this plan:

1. Parents are afraid of bringing young children to a Child Guidance Clinic (even disturbed ones). They are afraid of the stigma of psychiatry and afraid that whoever goes to a psychiatric clinic is "mental".
2. A mother often has a strong wish to deal with her child on her own. She is afraid of seeking help and afraid of having done something wrong to have to do so. She is afraid of not being a good enough mother.
3. She is afraid of having transitory difficulties exposed and has the strong wish that her child will grow out of it.
4. But the main reason for not having this service is that our clinics do not make a point of providing it. We are too busy with our large number of referrals of disturbed latency children and adolescents that we do neglect this area. We, ourselves, have fallen into the trap of thinking of a young child referred as "not disturbed enough for treatment" and hope that he will grow out of it on his own.

If we are willing to spend more time on preventive aspects of child psychiatry we would advertise the fact and have pediatricians, workers in Well-Baby Clinics,

nursery schools and Day Care Centers tell the mothers of the children in their care about it. We would make our wishes to work with mothers of young infants known and would try to have the concept of "Child Guidance" include normal child development. A service of this kind in connection with a child guidance clinic could also provide an additional perspective in the training of child mental health workers, whether they be trainees in child psychiatry, psychology or social work. Longitudinal studies of children in their families provide better insight into the disturbances of older children. Last, not least, much valuable material could be collected which would lend itself to more research into developmental processes in young children and their families, both from a horizontal and a longitudinal point of view.

A FOLLOW-UP OF RECOMMENDATIONS BY A SCHOOL-MENTAL HEALTH REFERRAL SYSTEM: PROBLEMS AND RECOMMENDATIONS

Billie F. Corder, Ed.D.

Co-Director, Psychological Services

Child Psychiatry Residency Training Program

Dorothea Dix Hospital

The Wake County Inter-Agency Screening Committee (WCISC) is composed of mental health professionals representing county agencies offering services to children and representatives from special education and personnel programs. It is typical of many mental health-school liaison committees functioning throughout the county which serve as first line screening for service to emotionally disturbed children within the school system. Typically these groups review material on children referred by teachers, counselors, and principals, make referrals and recommendations for treatment and other evaluation, and focus on individual case consultation. Intensive and detailed feedback of follow-up of referred children, which can point objectively and concretely toward optimization of referral processes, communication lapses and gaps in service continuums, are typically not available because of lack of funds and personnel services. The present study was funded by the North Carolina Department of Mental Health, and describes a one-year follow-up of 72 children referred within one year to the WCISC. Rates of improvement in children referred for various treatment programs are analyzed, problem areas and treatment continuum gaps shown in attempting to carry out recommendations are listed, and suggestions for optimization of functioning which may be applicable to mental health school liaison systems in general are discussed.

METHOD: Questionnaires and a structured interview were administered to each of the 72 children's parents, former teachers (at time of referral), and present teacher (one year later). Interviews and questionnaires focused on: a.) parents and teachers perception and behavior ratings of the child's primary problem areas at time of referral (previous adjustment). b.) Perception of recommendations of the screening committee by parents and teachers. c.) Record of treatment received and problems experienced in carrying out recommendations. d.) Perception of, and behavior ratings of child's present adjustment. e.) Suggestions for types of support needed in carrying out recommendations.

Behavior adjustment was defined by a rating scale which listed the concrete primary behavior problems described at time of referral and required ratings for severity on a scale of one to five defined by frequency of occurrence of behavior.

RESULTS: Recommendations by the WCISC fell roughly into three categories: Treatment and services at the local Mental Health Center, often supplemented by other special services (54%), recommendations to implement behavior modification programs in school, often with referral to supplementary services (26%), and referral for miscellaneous community agencies such as DDDL, Dix Vocational Rehabilitation, etc. (20%)

Only 13% of the respondents reported that the WCISC recommendations were followed in their entirety. Partially followed recommendations were reported by 40%, and 45% followed *no* recommendations. Reasons given for failure or partial failure to follow recommendations are shown in Table I.

TABLE I
REASONS GIVEN FOR FAILURE TO FOLLOW RECOMMENDATIONS

1. Transportation problems to treatment agency	9%
2. Child moved to another area	16%
3. Parent refused to accept recommendations	27%
4. Parent stated they couldn't understand recommendations	11%
5. Teacher felt unqualified to use Behavior Modification	11%
6. Teacher stated couldn't understand recommendations	4%
7. Discontinued M.H.C. treatment because of lack of understanding of treatment goals and process (parent)	14%
8. No room in recommended school program	1%
9. No reasons given	7%

Children were rated as improved (or unimproved) when they showed one rating scale score difference on two or more of the behavior ranking scales; 51% were ranked improved and 35% unimproved or worse, with 14% who were not ranked by respondents. Shown below in Table II were programs or procedures which were followed in cases resulting in improved functioning.

TABLE II
TREATMENT RESULTING IN IMPROVEMENT

	<i>Total % Improved</i>
1. Use of Behavior Modification by teacher	15%
2. Placement in special school classes	19%
3. Increased individual attention given by teacher (in lieu of WCISC recommendations)	23%
4. Tutor outside school	8%
5. Mental Health Center treatment	15%
6. Medication only	4%
7. Treatment by school social worker	4%
8. Plastic surgery or dental surgery	4%
9. No treatment given (no reason known for improvement)	8%

Suggestions for improved services focused on feelings of helplessness experienced by teachers when parents refused to co-operate with recommendations, or when behavior modification or other programs were recommended and the teacher felt inadequate and unsupported in her attempts to follow these programs (and for which they had typically received no previous training in their own educational background). Most teachers reported frustration and asked for additional support and assistance in attempting to interpret recommendations to parents.

DISCUSSION AND RECOMMENDATIONS: Communication difficulties were apparent both in teachers' inability to interpret for themselves and parents the case oriented, individualized recommendations made by mental health professionals, and in problems in recording recommendations on any school records. For example, teachers afraid of the effects of "labeling" children and uncertain of their interpretations of recommendations had difficulty in recording these in any form in the pupils' records. As a result, 53% of the "present teachers" surveyed were unaware that the follow-up students had ever been referred by his previous year's teacher to the WCISC, and had no knowledge of recommendations for treatment or of previous special school related problems. If liaison groups wish to function on this type of case consultation basis, it appears apparent that more individualized follow-up and support for each case must be given, i.e., cases assigned individually to group members for help in interpreting results to parents and teachers, as well as facilitating treatment recommendations. More effective methods for recording the referral process should be developed; material might be recorded in a child's school folder simply labeled as, "This child needed special help last year and was referred to the WCISC". Resistance to recording might be further reduced by keeping the records of the referral, recommendation, and routine forms for follow-up in a separate folder in the principal's office with a notation of its location in the child's cumulative folder.

If individualized, case consultation approaches are not feasible, liaison groups might reorganize to affect the school system as a whole by concentrating on developing teacher and parental education programs and by serving as an advocacy group which provides on-going records of problems in securing adequate mental health services for school children and by actively seeking to develop and expand these programs.

The necessity for developing more mental health services within the school system was readily apparent in the 27% rejection rate of parents who refused to participate in any agency services outside the school, giving reasons which reflected lack of understanding, fear, and mistrust of any mental health service. These same parents might more readily agree to some treatment program within the school system itself, as evidenced by their willingness to allow the child to be referred to the school based WCISC. Liaison committee groups might use their advocacy role to gather continuing data to establish the need for these school based services, publicizing these needs to legislative and other relevant funding sources.

Results showed many teachers feel unprepared to use behavior modification techniques and many other programs recommended by the WCISC, without some additional training and on-going supervision in the classroom.

In most areas, mental health centers are severely limited by immediate demands for service and are unable to provide this training and supervision. The development, utilization and training of teachers themselves will probably represent the primary source of help for children showing disturbed classroom behavior until funding is increased for school counselors and social workers. Liaison groups might concentrate on developing and building support for utilization of a resource "training library" of films, video-tapes and "on-call" workshops by mental health agencies which could focus on a variety of specific problem areas

(handling aggressions, learning disabilities, etc.). School officials would probably be responsive to requirements for providing teacher training time for utilization of such materials if childrens' needs were effectively and dramatically documented. One method of extending the effectiveness of such materials resources might be to develop a "resource file" of teachers, identified through a county wide survey questionnaire, who were willing to take extra training in behavior modification, learning disabilities, etc. These "resource" teachers might then be given special recognition (higher pay categories, first choice of teacher aides, on-going education credit) and released for one extra planning period per day (perhaps by parents acting as teacher aides, or preferential teacher aide assignment) when they might serve as "on-call" consultants for phone or individual consultation with teachers within their own school or within the county system in their areas of special skills.

COLLABORATIVE USE OF CASEWORK AND ROLE MODELING IN TREATING PARENT-CHILD INTERACTION

Jay C. Williams, M.S.W. Francis H. Copeland, A.C.S.W. Shirley Sanders, Ph.D.
Division of Child Psychiatry
North Carolina Memorial Hospital
University of North Carolina

Our setting is the Child Inpatient Unit of the North Carolina Memorial Hospital. We serve children from ages 3 to 13. It is staffed by a multi-disciplinary team, and provides evaluation and short-term treatment of 2 to 6 months duration. In the three years the Unit has been operating, it has been our experience that treatment of the child is enhanced by directly treating parent-child interaction. A program called Corrective Social Interaction Therapy, or more simply, "role modeling", is being researched to serve this purpose. Role Modeling is a standardized program to teach parents and children more satisfying ways of interacting. The program involves a sequence of 8 to 15 twenty minute sessions in which parents and child are taught several basic communication skills. These include following¹, modeling², positive feedback, limit setting and compromising. Later sessions are used to rehearse these skills as they relate to problems of the family's choosing. Teaching is done through role playing in which therapist, parents and child all play each role in turn. Statistically significant changes in parent-child communication patterns have been demonstrated by sampling communications before and after participating in the program.³

Exploration of means to make optimum use of role modeling within the Unit's overall treatment program are on-going. One such area of exploration is the collaborative use of role modeling and family casework. Parents of children treated on the Unit are involved in casework, provided out of recognition that enhancing the parents' psychosocial functioning, and thereby the child's environment, is important to the success of the child's treatment. The frequency, modality (i.e., individual, conjoint, or family), and the focus may vary, but parents are almost always concerned about their adequacy as parents.

Role modeling sessions tend to bring this concern into relief and to bring out a broad spectrum of related feelings. Families are asked to discuss how they have felt about sessions, but limited time and scope make it difficult to explore these feelings in depth within a role modeling session. Consequently, we have found it useful for the caseworker to observe role modeling so that he can pick up on concerns generated in the session and discuss them in a casework interview immediately following. Here, time, breadth of focus, and the relationship facilitate using this material to the family's greatest advantage.

What, specifically, are some of these feelings? Many parents are already feeling anxious, guilty, ashamed, or angry about having a child in need of psychiatric treatment. Some of the ways these concerns are brought out in response to role modeling are as follows: "Will they think I'm a bad parent?" "Have they asked me to do this because they know it's my fault?" "How will I feel if this

1. Following refers to showing uncritical attention by describing, repeating back, or imitating.

2. Modeling refers to teaching by demonstration of example.

3. Sanders, Shirley and John Boswell, M.D., Corrective Social Interaction Therapy, *Psychiatric Forum*, 1973.

proves it's my fault?" "What will we talk about if we can't talk about Johnny's problems anymore?" "Will Johnny see that I'm scared and that I don't know how to handle everything?" "Will he still respect me and love me if he does?" "Will they tell us to interact in ways that don't work for us and take away the only ways we know of getting along?" "What then?"

At least initially, these concerns are likely to be expressed indirectly. They may take the form of reluctance to discuss role modeling, but more often, they are expressed as a criticism of the program. For example, parents have said "Johnny doesn't really act that way at home", or "I'm sure it helps other people, but we already understand each other."

These concerns may be experienced by parents as a paralyzing generalized anxiety. But when parents can be helped to clarify them and relate them to particular unsatisfying interactions, this same anxiety can be productively channeled to motivate change. These examples will help to illustrate:

John is a 12 year old with a history of school behavior problems. He and his parents participated in role modeling done collaboratively with conjoint and family casework. In early casework interviews, Mr. and Mrs. T. complained that "they treat us like we're so stupid in role modeling". After some discussion, they recognized that they were feeling "stupid" because of their inability to help John with his problem. In a family interview, a repetitive pattern of dealing with John's school troubles was pointed out to them: Mr. and Mrs. T. took turns lecturing John. He responded by "tuning out". His frustrated parents then lectured him all the more doggedly. They recognized their frustration and John's inability to listen to them. Means of making this interaction more satisfying were discussed. The caseworker reminded Mr. and Mrs. T. of the "following" exercise they had been practicing in role modeling sessions. When they began to follow what John was saying, he did not "tune out", but discussed his ambivalence about assuming responsibility for his own actions—a feeling he had previously not shared with his parents. Mr. and Mrs. T. expressed pleasure with the outcome of this interaction.

This example illustrates several ways in which role modeling and casework complement one another. First, role modeling brings into relief the parents' feelings of helplessness in dealing with John's behavior, thereby making this concern more accessible in casework interviews. Second, the caseworker provides clarification and help in particularizing interactions which cause Mr. and Mrs. T. to feel as they do. Third, role modeling provides them with a tool with which to change this interaction. Finally, the caseworker provides the encouragement to persevere in integrating this tool which may at first seem awkward, mechanical and difficult.

The following is a second example:

Bill is an impulsive, learning disabled 9 year old who was referred because his adoptive mother found him "hard-headed", hyperactive, and difficult to manage. She and Bill's stepfather participated in role modeling with him. Mrs. N. had adopted Bill, the illegitimate child of her younger sister, when he was 3 days old. She had wanted children of her own but was un-

able to conceive. She denied her disappointment and anger at Bill, whose behavior problems have reinforced her feelings of inadequacy, but she related to him with many angry demands. Bill and his parents felt they had derived little benefit from five years of outpatient treatment. In role modeling sessions, Mr. and Mrs. N. found it difficult to follow Bill without questioning, and difficult to teach him tasks in a way which was simple enough for him to understand. In discussing this in the casework session which followed, the couple gained some awareness of Mrs. N.'s anger and need to control. In a later role modeling session, they surprised themselves with their success in using the following technique to avoid the power struggles which often would ensue they asked Bill to do something he didn't want to do. In discussing the session with the caseworker and role therapist, Mrs. N. realized that she sometimes unwittingly provoked Bill by, for example, asking him what he wanted for dinner and then serving him something different. With this realization of her own role in Bill's negativism, Mrs. N. became motivated to find other ways of interacting. The caseworker suggested she try following and compromising during Bill's weekend visits home. Mrs. N. did this very successfully and felt pleased with herself and positive toward Bill.

In this example, role modeling sessions highlighted problems in parent-child interaction. This motivated Mrs. N. to discuss these interactions, and the feelings involved, with the caseworker. The caseworker then helped the family to identify situations in which role modeling techniques might be used to produce more satisfying interactions and she gave support as the parents tried this out.

Another area of collaboration is around transference resistances. In role modeling, as in any treatment relationship, patients develop transference feelings to the therapist. Often transferences can impede an individual's participation in the exercises. The time and scope of a role modeling session may not be sufficient for an individual to reach any resolution or to further his understanding of himself, or grow from the experience. But the transference often can be dealt with in casework sessions. This example illustrates how a transference resistance in role modeling was partly worked through with the caseworker's help:

Mrs. G., a forty year old divorcee with a history of thought disorder, participated in role modeling with her 13 year old only child, Larry. Larry was experiencing problems of school refusal and destructive rages. In early role modeling sessions, Mrs. G. was quite resistant, complaining that the exercises were pointless since she already understood Larry very well. The role therapist and the caseworker decided to meet jointly with Mrs. G. to discuss her feelings about role modeling. Mrs. G. stated that the role therapist made demands of her which she couldn't meet. In reality, the role therapist gave her simple instructions and much positive feedback. But Mrs. G. was transferring feelings from her own parents whom she described as demanding and critical. In this joint interview, and in subsequent casework interviews, Mrs. G. was helped to test the reality of her perception and to acknowledge that it had been distorted. Subsequently, she began to participate less resistantly in role modeling. The final baseline showed a marked increase in following responses, and some increase in compromise responses as well.

In this example, role modeling stimulated transference material which was brought up in casework interviews. Through collaboration, the role therapist and the caseworker were able to understand the transference which was impeding Mrs. G.'s participation in the exercises. The caseworker then helped Mrs. G. to test her perception of the role therapist. Results included both a reduction of resistance to role modeling and an increase in Mrs. G.'s self awareness.

Similarly, transferences arising in the casework relationship are sometimes generalized to the role therapist or to the entire situation. For example:

Miss P. is a passive, dependent, and very obese 35 year old woman. She participated in role modeling with her son, Tyron, who was referred because of withdrawal from peers alternating with violent and seemingly unprovoked attacks. In casework interviews, Miss P. complained that the school principal made many demands on her to control Tyron's behavior, but that he chose to suspend Tyron rather than making any effort to help her deal with this behavior problem. Later she complained that her parents kept her at home to care for them until their deaths, but allowed her two siblings to move out at an early age. Miss P.'s father died several weeks after Tyron was admitted. After this occurred, she began to relate to the caseworker as though he were demanding that she come to interviews from which she saw no benefit. Her perception of the caseworker seemed to generalize to the role therapist and to the role modeling situation, and she sometimes asked to skip role modeling sessions. Eventually, the caseworker pointed out to her that she seemed to perceive him as making demands when he intended to listen and offer support. In subsequent interviews, she was noticeably less guarded and did participate in role modeling sessions. At the time of Tyron's discharge, she had not participated regularly enough to complete the role modeling program. But she did begin to tell the caseworker in follow-up interviews of instances in which she had been able to "follow" Tyron's feelings when he became angry and prevent him from losing control as he had so often done in the past.

In this example, Miss P.'s feelings about her demanding parents and about the school principal were transferred first to the caseworker and then to the role therapist. It was necessary for the caseworker to help her test the reality of this perception before she could begin to feel that the role therapist was offering her a helpful tool.

Finally, collaboration between role therapist and caseworker provides diagnostic feedback in both directions. For example:

Judy, an 11 year old with a diagnosis of anorexia nervosa, participated in role modeling with her parents. In initial casework interviews with the parents, they seemed to relate comfortably and openly, but in the role modeling baseline with Judy, they became rigid in posture and said little. This brought to the caseworker's attention their extreme guilt about Judy's illness and their reluctance to reveal their interactions. This concern became the focus of subsequent casework interviews. In casework, they also discussed their discomfort with expressing anger. This concern was shared with the role therapist who set up an exercise to model acceptance of angry feelings.

In summary, our experience suggests that role modeling and family casework can be complementary parts of a child treatment program. The effectiveness of each seems enhanced by close collaboration between therapists. Specific areas in which collaboration has been helpful include dealing with concerns about parental adequacy, dealing with transference resistances and increasing diagnostic understanding. One implication of our experience is that modeling or behavioral interventions need not be seen as competitive with the more traditional relationship-oriented treatment modalities. Each can contribute in different and complementary ways.





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Manuscripts and editorial comments submitted for publication should be mailed to:

Drs. G. Tolley and T. Curtis
Editors-in-Chief
N. C. Journal of Mental Health
Dorothea Dix Hospital, Station B
Raleigh, N. C. 27611

Manuscripts should be submitted in triplicate, double spaced, and total no more than 15 typewritten pages. The format of headings, tables, figures, citations, references, and other details should follow the style described in the *Publication Manual of the American Psychological Association*, available from the Association at 1200 Seventeenth Street, N.W., Washington, D. C. 20036. Tabular material, drawings and charts must be limited, due to publication costs, and should be submitted on separate sheets.

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**THE JAMES L. CATHELL
MEMORIAL ISSUE**



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James L. Cathell, M.D.

1914-1970

IN MEMORIAM
James L. Cathell, M.D.
1914-1970

On June 14, 1970, Dr. James L. Cathell died in Wilmington, North Carolina where he had lived with his wife Drusilla, his son Luke and daughter Marty for the past three years in their beach home on the sands of Wrightsville Beach overlooking the blue Atlantic. Following Dr. Cathell's death a memorial fund was established. This issue of the North Carolina Journal of Mental Health is dedicated to Dr. Cathell, to his work and his special interest in assisting children with emotional problems.

The son of a physician, Dr. Cathell was born in Lexington, North Carolina, on September 2, 1914. Graduating from Lexington High School in 1930, he entered Wake Forest College the same year and graduated in 1933 having completed his pre-medical requirements. He then entered Emory University School of Medicine, Atlanta, Georgia in 1933, graduated in 1937, and completed his internship at Grady Hospital in Atlanta in the following two years. Following his internship, he entered into private practice as a general practitioner in Lexington. It was during the years from 1938 to 1949 that he formed the close identity with general practitioners which served him so well later as a consultant.

In 1949, Dr. Cathell joined the staff of John Umstead Hospital in Butner, North Carolina. The next fourteen years of his association with John Umstead Hospital were years of rapid growth and progress in the field of psychiatry and mental health with the application of new findings in psychiatry including crisis intervention approaches developed during the war, the value of the tranquilizers and the "opening up" of hospitals. During those years particularly, Butner was a family community and the Cathell family became a part of that close knit group. Dr. Cathell served as Assistant Medical Superintendent from 1953 until 1955 and as Medical Superintendent from 1955 until 1963. During these years, he completed his residency training in psychiatry on a part time basis with the program at North Carolina Memorial Hospital in Chapel Hill and became Board eligible in psychiatry in 1959.

The dedication in 1971 at John Umstead Hospital of the new medical building as the "James Luther Cathell Medical Services Building" symbolized his contribution at Butner and the love and respect which he obtained there.

By training, background and natural inclination, Dr. Cathell was particularly well suited for the work which he undertook beginning in 1964. From a base in Morganton, North Carolina, from 1964 until 1967 and then in Wilmington at Wrightsville Beach from 1967 until 1970, he became the first physician in the United States to devote full time effort as a psychiatric consultant to general practitioners as director of the "Psychiatric Post-Graduate Consultation-Educational Project" for the North Carolina Department of Mental Health. Referred to as the "Circuit-riding Psychiatrist"¹, he provided psychiatric consultation to general practitioners in Alleghany, Watauga, Avery and Caldwell Counties and then later from his base at Wrightsville Beach, to physicians in New Hanover,

Brunswick and Pender Counties. During the first two years of the consultation to general practitioners in western counties, the admissions from those counties to Broughton Hospital in Morganton showed a relative decrease of 25% through the help that Dr. Cathell provided the physicians in working with their patients and with their family members. In his work in the eastern counties, he engaged in particularly assisting physicians and others in working with children who had emotional problems, learning problems, and problems in adjustment. His office in Baby's Hospital at Wrightsville Beach symbolized this concern and effort.

Dr. Jimmy Cathell is best seen through the eyes of his family, his friends and his colleagues. He wished to be remembered as "a fellow who enjoyed everything" in his relationship with his family and his associates. The annual seminar of the consultation project was a highlight for the Department of Mental Health, with an opportunity to review with fellow North Carolinians and colleagues from many other states, developments and findings in this area of work. General practitioners came to Raleigh not only to participate in this learning experience, but to express their gratitude for the assistance which they had been provided. His colleagues have contributed their recall of him as a person in his work in this effort. Dr. Elams Kurtz remembers Dr. James Cathell as a great teacher who "captured verbal and nonverbal clues with a comfortably fixed gaze whereby he obtained quick acceptance in verbalization of problems. Yet in this, he maintained the doctor-patient relationship of the attending physicians. He helped the office aides accept their feelings about patients and to utilize them in patient evaluation." Dr. Brooke R. Johnson, Area Director of the New River Mental Health Program, similarly writes "my first impressions emphasized his casual dress." . . . symbolic of his casual nature which typifies his relationship of everyone. Dr. Cathell was a genuine consultant . . . he was a facilitator, able to sense significant events that were happening and get feedback in such a way that it could be accepted. When he would leave me, I would feel that I had been helped but that I still had responsibility for myself and what I was doing." Dr. Charlie Vernon, his friend and psychiatric colleague of many years writes "Jimmy was respected and trusted by the practitioners he visited here and about—John Dees and Harold Pedin in Burgaw and Gene Wallin in Southport, Gerald Points and Bob Andrews here in Wilmington."

Mrs. Cathell, affectionately known as "Drukie," resides at Shell Beach with "Princess," her daughter age 14, finishing the eighth grade of school. Drukie is deeply invested in civic work at church, at school and in the community. "Luke", now age 23, is a computer programmer with Duke Power in Charlotte following his graduation from North Carolina State University in Raleigh. They and Dr. Cathell's friends and colleagues are his true memoriam.

James W. Osberg, M.D.

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(L to R) Mrs. James Cathell, Luke Cathell, Marty Cathell.

ANNOUNCEMENT

THE JAMES L. CATHELL MEMORIAL AWARDS

In addition to endowing this issue of the North Carolina Journal of Mental Health, two special awards have been designated by the North Carolina Foundation for Mental Health Research as a memorial to the late Dr. James L. Cathell. These awards will be presented to the authors of each of two papers dealing with the mental health of children.

Recognition and encouragement of those dedicated to mental health services for children seems an especially appropriate memorial to Dr. Cathell in view of his personal and career interests in children and families.

GUIDELINES:

The prize papers will be chosen from among those dealing with research or theoretical matters in the prevention, treatment or diagnosis of psychiatric disorders of children and youth or with program development issues in mental health services for children. Research should have been completed within the past two years and should not have been previously published. Papers should be no more than fourteen double-spaced typewritten pages, and four copies should be submitted by December 1, 1975 to:

*The James L. Cathell Memorial Awards Committee
c/o Dr. Billie F. Corder
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Raleigh, North Carolina 27611*

THE AWARD:

Each of the two papers selected will be awarded a cash prize of one-hundred dollars, and together with a suitable announcement will be published by the North Carolina Journal of Mental Health. Awards will be made by March 1, 1976.

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EDITORIAL FOREWORD

THE JAMES L. CATHELL MEMORIAL ISSUE

Dr. James Osberg has graciously served as Guest Editor for this special issue of the *North Carolina Journal Of Mental Health* dedicated to the memory of Dr. James L. Cathell. In keeping with Dr. Cathell's interest in work with children, this issue consists primarily of papers presented at the 1975 Southeastern Regional Meeting of the American Association of Psychiatric Services for Children held in Chapel Hill, North Carolina.

The Editors

THE NORTH CAROLINA JOURNAL OF MENTAL HEALTH

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THE JAMES L. CATHELL MEMORIAL ISSUE

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NORMAL DEVELOPMENT OF THE PRE-SCHOOL CHILD

Rex W. Speers, M.D.*

*Training and Supervising Analyst, Child Analyst, Pittsburgh Psychoanalytic Institute. Clinical Associate Professor, Child Care Child Development, School of Health Related Professions, University of Pittsburgh, Pittsburgh, Pennsylvania.

To approach the subject of the normal development of the pre-school child is an enormous task and one that I could not possibly cover in many seminars, far less in a one-hour period. However, there are some high points in that development which I would like to discuss with you today but remember I am being sketchy and leaving out much that is important.

Anna Freud recently stated that our knowledge of child development has grown by leaps and bounds in the past 40 years yet there are gaps remaining which will take years to fill. She points out that there have been only two definitive studies covering specific periods of time in the child's life: Those of Spitz' on the first year of life; and, more recently, the studies of Margaret Mahler elucidating the separation-individuation process. I feel Anna Freud has been modest in her failure to mention her own contributions, specifically, "The Developmental Lines." Certainly that publication ranks as one of those definitive contributions to our child development literature.

In this paper I would like to review with you the separation-individuation process, which has been hopefully completed by the time we categorize the child as "pre-school"; and, following that, I would like to outline some of the developmental characteristics of children in the age period 3 to 6. Let me assure you that my presentation will not be armchair theorizing, but rather, the result of nearly ten years of extensive study of normal children in normal situations. I have long been associated with the Arsenal Family and Children's Center and thus afforded the opportunity to study children from what one might call reasonably normal families and who have exhibited reasonably normal development. In addition, I have studied children at the Shady Lane Schools both at the pre-school and elementary levels and these too are basically normal children. In the past two years I have also had the opportunity to study children in day care settings.

Margaret Mahler, in her 30 years of research on the separation-individuation process, has provided us with a framework in which we can observe the behavior of children with their mothers and thereby scientifically speculate on the intrapsychic development of each child. Dr. Mahler's work has been duplicated in many centers throughout the country; in some studies of a predictive nature, and, in some studies her work has been expanded and made even more specific. My own studies have along the lines of the development of libidinal object constancy, self constancy, and the readiness of a child to enter a pre-school program; and, the relationship between separation-individuation and its variations from the normal or usual, and the play ability of the child. I have also attempted to follow these children into the academic setting to make a third correlation; that is, separation-individuation, play ability, and academic success.

You will recall that Dr. Mahler designated the first three weeks or so of the as the period of normal autism. As you know, this autistic phase is not absolute inasmuch as the newborn brings functioning perceptual apparatuses into the world. We hold no fantasy that the child has an intrapsychic life at that time and therefore would not agree with the postulates of Melanie Klein as regards this period of development. We do applaud the contributions of the neurophysiologists MacLean and Pibum whose studies have enabled us to gain further understandings of this earliest period. In its simplest form, I would suggest that the stimulation experienced by the infant is of the order of a disequilibrium which lowers the perceptual threshold and results in a scanning of the environment, as well as releasing pre-patterned affectomotor responses from the child. The response from the environment, if of a "good" order, not only produces physiologic satiation and comfort with the restoration of physiologic equilibrium but also results in a primitive memory trace of a "good self object-affective experience" which is stored in the primitive brain. In those instances in which the biological organism is unable to either receive the environmental response or to effectively regain homeostasis, or in those instances in which the environmental response is not "good", the experience is stored as "a bad self object-affective experience." These repetitive-cyclic experiences, specifically the lowering of the perceptual thresholds when the child experiences stimulation and the subsequent scanning of the environment, provide the first experiences of the inside-outside variety. It is also in these repeated rhythmic experiences that the child's attachment to the mother occurs. The child at this point enters the phase of symbiosis. Dr. Mahler has stated that all stimuli subsequently pass through the envelope of the symbiosis and thereby the mother's role as an organizer for the child's inner and outer experiences becomes manifest with the first structuralizations as the body ego. I want to emphasize that the mouth is the primary focus of these transactions, i.e., the oral phase, but in no way do I lessen the importance of all of the other experiences that the child has in the symbiosis. Winnicott has put all of these experiences under the terms "the holding behavior" of the mother. To my mind all the primitive perceptual apparatuses are vital to this concept: i.e., the auditory, the visual, smell, taste, equilibrium, proprioception and tactile. The growing ego's capacity to integrate these various stimuli further the development of "me-not me" experiences. I think this can best be illustrated by the child's finger in mouth experience versus finger in mother's mouth experience. If the child puts the finger in his own mouth he gains two experiences, i.e., that of finger in mouth and mouth around finger. If he puts finger in mother's mouth he only gets the one experience of something around finger. It is in these repeated diacrytic experiences that the me-not me differentiation is furthered. When one combines these perceptual experiences with the patterned affectomotor experiences one can appreciate the increasing development of the ego and its synthesizing activity. To my mind one of the more crucial aspects of this development involves the growth of cognition as a primary autonomous ego function. It is essential that the child be able to intellectually "know", in self observation, of the various experiences he has. Fenichel, many years ago, stated this point when he said that the child changes positions and then takes cognizance of that change.

You will note that throughout a child's development the ontogenetically determined maturation of a biological apparatus initiates and precedes the psychological aspect of the upcoming sequence. At approximately five months of age the child and mother are at the height of the symbiosis and it is at this point that the mother is the psychological mother and is irreplaceable. The psychological mother, according to Mahler, is "the mother who declares herself to be the mother and thereby becomes the mother of symbiosis and later the mother of separation." Obviously this concept becomes of extreme importance in the present massive movement towards day care and the role of the day care giver in the separation-individuation process. I have suggested that we refrain from using terms such as substitute mother or mother surrogate in these situations for it blurs and confuses the role of the day care giver. The process of separation-individuation *must* go on with the psychological mother and regardless of the number of other care givers, that particular process is one involving the mother and infant child. Dr. Mahler has stated that at the height of symbiosis, at approximately five months of age, the psychological mother is exclusive and irreplaceable. My studies would certainly verify this notion and even if the mother should die at this time she remains the psychological mother and is not psychologically dead for the child until a mourning process is undertaken in late adolescence. All other care givers are just that, care givers, and are not part of the imago "mother."

The biological maturation that occurs at the height of the symbiosis is the development of distance vision. Thus, at approximately five months of age the child, in effect, can see *beyond* mother. This maturation initiates the "hatching" process which Dr. Mahler calls the separation-individuation process and which will go on until approximately 30 months of age. The first phase of hatching runs from about 5-10 months of age and is called the phase of differentiation. In this period the child's activities are those of clearly defining self from non-self; primarily mother. The child is at this point very much a lap baby and you will notice them turning their heads toward the external world. One of the outstanding behavioral manifestations of this phase is the development of stranger anxiety. This is the point at which the youngster scans a not-mother face and compares that face with the intrapsychic mother face. When the discrepancies are noted a child experiences anxiety. In most instances he will turn back to the mother, and through all of the primitive perceptual apparatuses regain the assurances of "mother." You will notice such children turn their eyes from the stranger, bury their faces in the neck-shoulder area of the mother and cling to her tenaciously. On many occasions I have been able to demonstrate that the significant aspect of this reaction is around the smile. Mother's smile seems to be the most specific visual aspect of "mother." Thus, when the stranger smiles the discrepancy is readily noted by the child and stranger anxiety ensues. This anxiety may be for any "not mother" including father, grandmother, siblings, etc. The degree of anxiety may be intense or relatively mild. It may only be shown as a sudden quieting and staring by the child. The experiences then are of "me" and "not me", of "me" and "mother", and of "me" "mother," and "other." Thus the differentiation phase is aptly named. You will remember that during this phase the child

moves from the lap baby to the knee baby to the foot baby, and that all of the phenomena of motor development is incorporated into the differentiation phase. I only wish to comment on the enormous amount of learning that goes on in this five-month period and to marvel at the learning ability of the infant child and, of course to wish that at my age I could learn so readily.

The onset of the practicing phase of the separation-individuation process from about 10 months of age to about 16-18 months of age is again ushered in by a biological maturation: that is, upright locomotion. For the first time the child is now able to actively separate from mother as opposed to all of his earlier experiences of passive separation. Although we say the child separates from the mother this is only in a physical sense. I see the child as investing all of his psychic energy into the joy of muscle activity, the joy of exploration, and agree with Edith Jacobson's description of this period as being one of the child's having a love affair with the world. To my mind there is no psychological separation. On the contrary, it appears to me to be one of an omnipotent dyad in which the child experiences mother as omnipresent. You will notice that he has little concern as regards falling, getting hurt, things being in the road, etc. His only goal seems to be to explore all of the marvelous things "out there" which his eye perceives. A brief comment on his mode of exploration. You will note the child sees the object at a distance; moves toward the object; takes the object in his hand; shakes it; brings it to the near vision position; smells it; and, finally licks it or tries to put it in mouth. I suggest to you that this is his way of "knowing" the object. You will also notice that periodically during this phase the child will suddenly stop whatever he is doing and return to his mother. These initial returns are regressive; i.e., the child will crawl up into mother's lap, into her neck-shoulder area, and will once again taste her, smell her, and cling to her body. He will then get down off her lap and return to his exploratory activity. The increasing sophistication of the mode of this "emotional refueling" is evident. Over the months one may note that a child gradually uses a specific modality for refueling. For instance, the child will be in another room and suddenly will say, "Mother", the mother replies, "What?" and there is no answer. That is a verbal-auditory mode of refueling. Another child may dash to the kitchen, peek around the corner of the door and see mother and then return to his activity: a visual mode. Another child may have to touch mother to gain adequate refueling. You will also note during this time that a child becomes increasingly aware or sensitive to hurts and to things being in his road. This represents an increasing awareness of both separateness and of the lack of omnipotence. The "rapprochement crisis" occurs at that point at which the child discovers not only his separateness from mother and the fact, therefore, that mother is not always present, but also intellectually *knows* of his lack of omnipotence and, therefore, of his helplessness. This indeed is a crisis. There is little question but what the handling of this crisis becomes a period in preoedipal development of the same order and magnitude as the oedipal crisis in the oedipal period. I only wish to mention the distribution of narcissism in these terms. In other words, if the rapprochement crisis is not dealt with adequately we can expect that the distribution of narcissism will be adversely affected in the child. The crisis frequently occurs around a baby

sitting situation. As you know, in the 10-16 month range the mother may come and go at will. She is relatively freed from the consistent 24-hour a day, 7-day a week involvement with the child. Baby sitters are no problem at this time inasmuch as the child will be comfortable with most anyone for rather long stretches of time. Between 16-18 months of age, the child's mother is out shopping and the baby is home with baby sitter. The baby sitter gets in touch with mother and worriedly tells her to come home quickly that something is wrong with baby. Mother comes in and finds the child as if in a panic. The clinging, crying, sobbing, screaming child can *only* be consoled by mother. Within the next 2-3 weeks the clinging and shadowing of the mother is quite remarkable. They literally won't let mother out of sight. Most mothers talk about this clinging as the child being under her feet, hanging onto her skirts and not even allowing her to go to the toilet without his presence. It is apparent that the intellectual discovery of separateness, of the lack of omnipotence, and of relative helplessness, all which the child experiences at this crisis time, is of great importance. The child subsequently attempts to restore an omnipotent dyad by his clinging, shadowing behavior. To me, it is a period in which the child is unable to tolerate the narcissistic wound of helplessness; endows the mother with omnipotence, and, by clinging to her shares in that omnipotence. The handling of this crisis as I have said, is of utmost importance. I basically can see three ways in which it is handled and of course all combinations of these: To the one extreme the mother acts as if it were true that the child could not survive without her and she thereby becomes the smothering, over-protective, etc., type of mother. She doesn't let the child out of her sight. The subsequent internalized self representation in the child becomes one in which he experiences himself as being unable to cope without mother. The opposite extreme is the mother who in effect says "You are a big boy/girl now and stop bothering mother." This then forces the youngster to do it himself. The self representation of such a child is one of "I don't need anybody, I can do it myself." The "good" mother recognizes the crisis nature of the situation, permits the regression, and takes the child back into her bosom and supplies the appropriate comforting. She gradually turns the child around towards the external world and with a gentle pat on the bottom moves him out to explore again. However, she remains available so that he may return at any time for his necessary attachments and assurances. If handled appropriately, this period of difficulty will last about three weeks. If it is not handled appropriately, one sees a prolonged crisis of clinging, etc., which can extend over a good many years. And so ends the practicing period.

The rapprochement subphase is commenced after the resolution of the rapprochement crisis. It, too, is initiated by a biological maturation. This biological maturation is one of sphincter control potential with a psychological concomitant of a cognitive structure which is of the order of "knowing" of separateness, and of relative helplessness but of adequate trust in his own coping devices and of trust in the availability of mother. I cannot appropriately convey to you the sophistication of the level of organization that is evident in the rapprochement-phase child. It is indeed a highly sophisticated level of organization. The verbal-auditory mode of communication becomes the primary mode. One notes the

intense visual attention to the mother during rapprochement. The child literally gets into mother's face and demands the mirroring so necessary for the child's development of the sense of self, self esteem, self confidence, and the ultimate delineation of self versus object. Although Dr. Mahler believes this phase comes to an end at about 24 months of age, I think it is important to note that rapprochement lasts throughout our lifetime. Whenever we have been away from someone we care for and meet them again there is a "rapprochement"; a joyous reunion with a jabbering as to what each has done in the interim. Each separation of child from mother during the rapprochement phase is of this order and leads to object constancy and self constancy. Piaget's object permanency is clearly a structural acquisition related to the rapprochement crisis and is therefore part of the structure essential for libidinal object constancy but is not yet of that order. Repeated rapprochement experiences and the innumerable coping activities of the rapprochement phase child lead to libidinal object and self constancy.

The behavior of the rapprochement-phase child is one of "Look at me, watch me, let me tell you, and do you approve of what I am doing?" It is not a phase of "Show me", or "Tell me what to do." It is much more one in which the child is seeking a mirroring of his/her activities with approval being the primary need. Thus the child approaches the mother with something interesting, tells mother about something funny, or things that happened and looks intently into the mother's face to gain assurances of approval. This behavior is known as mirroring and is the child's looking into mother's face and seeing himself in terms of mother's reaction. Interestingly he can also see himself in mother's eyes as a visual reality. Certainly one sees then the increasing separation and individuation that is transpiring during this phase. Dr. Mahler closes this phase at about 24 months of age and speaks of a fourth subphase which she calls "On the way to object constancy." There is indeed an increasing sophistication in overall functioning of the child following the resolution of the rapprochement crisis all the way towards the development of libidinal object constancy.

I might remind you that concurrently in that second year of life the libidinal and aggressive drives have moved caudally to the anus and to the bowel products. You will recognize that the intertwining of these drive activities and the separation-individuation phases are essential aspects of overall development and my focusing on the process of separation-individuation is in no way meant to devalue the importance of the drive sequences. All of our writers over the years have spoken of the autonomy struggle that goes on in the anal phase two-year-old child.

Thus at approximately 30 months of age the child has developed libidinal object constancy. Let me be very specific about this terminology inasmuch as it has occasional considerable confusion when incompletely understood. Libidinal object constancy refers to the development of the libidinal object representation intrapsychically. This means that the mother is represented as a constant object in the psyche of the child. When I say constant I mean that she remains as an object representation whether or not she fulfills the libidinal needs of the child and whether or not she is present. At this point she is a composite mother, that is,

she is both the good mother who gratifies libidinal needs and she is the bad mother who deprives the child of gratification. These two object representations, that is the "good mother" and the "bad mother" are now fused into a single representation. *That* is the meaning of libidinal object constancy. I would like to illustrate by some clinical material how libidinal object constancy can be determined in a child. If I say to a three-year-old boy, "Where is mother?"; he may reply, "Home." I then ask, "What is mother doing?" He replies, "Cooking me lunch." I then state, "Perhaps mother is cooking baby sister lunch." At that moment the child may tear up and mutter "Maybe." This is illustrative of his having developed libidinal object constancy. Such a child knows that mother exists in spite of the fact that she is not present and is not devoting all of her time, energy, etc., to him; but rather, she might be doing something that has *no* gratification in it for him.

In this process of separation-individuation there is the second part of the hyphenated words, that is, individualism. As libidinal object constancy refers to the separation component, there is self constancy, referring to the individuation component. This means that at approximately the same time that an object representation becomes constant in the child's psyche a self representation which is a composite "good" and "bad" self, also becomes constant. At such a time the child has an identity—which means constant whether or not he is with mother.

I hope you will recognize that these are intrapsychic representations. They are internalized structures and now are independent of the external world. They also may have little relationship to manifest behavior. We have tried in many ways to determine whether or not a child at approximately three years of age is ready to enter our preschool programs. A not unusual criterion has been one of being toilet trained. This may or may not indicate preschool readiness. Having child and mother come to the school for a few hours' visit may not reveal adequate evidence as to whether or not he is ready for preschool. Therefore, how do we determine whether or not a child is "ready." Let me remind you that the development of libidinal object constancy and of self constancy is attained in a matrix of the familiar home environment. That means that familiar sights, smells, tastes, people, noises, textures and the like form part of the matrix of that constancy. When the child is removed from that home and environment and all its familiarities and placed in the nursery school milieu the matrix is different, new and unfamiliar. One might, therefore, fully expect some regressive phenomena in the face of this new situation. I have hesitated to use the word regression when dealing with the subject of object and self constancy. It seems to me they are mutually exclusive. I have preferred to use the notion of "recapitulation" to talk about that initial adjustment period that a child has when entering the nursery school. My work on the children entering the nursery school has convinced me that the entire process of separation-individuation is recapitulated in the nursery school milieu. I see this as a phenomenon relating to the matrix in which constancy is obtained rather than a regressive loss of constancy. Once the child has recapitulated this process we say he is adjusted to nursery school. The fact of this recapitulation and the necessity for the child to effect such a recapitulation renders arbitrary rules governing the inclusion or exclusion of mothers from the

nursery school unrealistic. Certainly there are children who have had multiple experiences in milieus other than at home. Such children will find the nursery school not an entirely new experience and will, therefore, make the adaptation without undue difficulty and may not have to recapitulate the process. This is not necessarily a recommendation that children have experiences in other milieus prior to entering nursery school. But it is a fact that some children will have other experiences which make the preschool milieu not too difficult for them to adapt to. On the other hand, most children have the familiar home as the milieu in which separation-individuation has occurred and the entirely new preschool milieu requires that mother be present while they effect an adaptation. In our experience this requires about five days if the staff is familiar with the process and with the concept of recapitulation of that process. The dilemma of under 3-year-old day care programs is one of our knowing that the separation-individuation process occurs between mother and child, yet there exists a necessity for out of the home placement. Providing the child with optimal experiences in both settings may be an insolveable dilemma. Research on "after day care hours" activity is much needed.

To return to the subject of the determination of the development of libidinal object constancy: I spoke to you of the interviewing of the child and the questions relating to the mother's whereabouts and activities as being useful in this regard; one should also use the developmental lines assessments. Dr. Dale Morter has developed a technique which I also find useful in this determination. This necessitates administering a Rorschach to the children. If one allows the child to see the Rorschach cards and gains their initial response and then waits five minutes and administers them again; children who are unable to recall their original response in at least 20% of instances, even after coaching and reminding, certainly have difficulty with libidinal object constancy. I say the Rorschach cards because they have some relationship to libidinal objects as opposed to using any other type of object which may only relate to object permanency and since I have defined the difference between object permanency and libidinal object constancy you will understand what I mean in this context. Obviously the absence of human figures or at least animate figures in the responses is also indicate of some lack of self constancy. I do not think that this type of screening, testing, interviewing, and developmental line assessment require an enormous amount of time or energy and therefore feel that it should be a prerequisite for determining whether or not a child should enter nursery school.

I would like very much to go into all of the variations and deviations from the normal process as we have studied them over the years but time does not permit this. I merely want to talk about two which may be variations from the normal but could be deviations and should be suspect. They are the "pseudo mature," and for want of a better word, the "immature." Obviously the pre-psychotic and the seriously deviated from the normal in terms of separation-individuation (such as the run and chase—darter) are more than suspect. I will concentrate on the pseudo-mature child inasmuch as he is the most likely to get into nursery school when he is in fact not ready for it. The pseudo-mature child may be either male or female: The girl is classically the "little mother" and the

boy the "little man." Both of these children have had a variation from the normal in their separation process and are indeed pseudo mature. They appear to be perfectly competent and in fact in many instances they are competent yet psychological they are unseparated children. These children are usually the delight of teachers inasmuch as they cause no trouble and do carry out mother's wishes that they attend the school and therefore are no trouble to mother. They separate immediately upon entering the school and seem to be fully in control and command and show no need for mother. Many of them also have no need for the teacher and this may occasion some concern in her at a later date but ordinarily she sees such children as a boon to her classroom. I regret that the boon is not forthcoming. A large percentage of these children will become ill by Thanksgiving or Christmas and be unable to return for the remainder of the year. Another group will, with ego restriction, maintain themselves throughout the school year as the competent child. The boy of this type will ordinarily have enormous difficulties during the oedipal phase of development—in fact they have a precocious oedipal phase which is intense and usually only resolved with great difficulty if at all. The girls, on the other hand, may have an intense oedipal phase, but seem to cope with it throughout the nursery school period and ordinarily show no effects from being pseudo mature until they reach preadolescence. At this point they encounter extraordinary difficulties and frequently become behavioral and school failure problems at that time—ordinarily around the end of the third grade or the beginning of the fourth. The boy, on the other hand, will experience his difficulties at the 4-4½ year period and may experience a rather intense depressive affect under the impact of oedipal defeat and castration threat.

The second variation from the normal, the immature, refers to those children who are continuing to struggle with the rapprochement crisis and therefore are immature as far as the development of libidinal object constancy is concerned.

The question of admitting the two variations to the nursery school is a difficult one. By and large the attitudes of most teachers is one of reinforcing the pseudomaturity inasmuch as that type of behavior is so desirable. The question of admitting the immature is not difficult inasmuch as they cry, cling, etc., and give a good deal of difficulty if they are admitted. The pseudo-mature child is very much apt to continue the pseudomaturity in the home environment inasmuch as this is both a cultural and family desired attribute. Therefore, to leave such children at home doesn't really solve the problem. It would be much more useful if the teaching staff would observe such children carefully, not reinforce the pseudo-mature behavior, and when they do see that the child does in fact need help that could be the moment they move in and not only behaviorally give the child assistance but assist him in his understanding that he is a little child and there are times when he does need help, and that this is quite acceptable. Again, I see the pseudo-mature child as putting a tremendous burden on the school staff inasmuch as they must be very astute in moving in on the child at a time of real need. Most of these children will refuse any offer of help in most any situation because it is contrary to their learned experiences of the need to be a big girl or a big boy. On the other hand, the immature type of child will be an obvious

problem to the school and may absorb all of the teacher's attentions if they are admitted.

I want now to turn our attention to the three year old normal child who is admitted to the nursery school and to describe and discuss some of the psychological and behavioral manifestations of such children. Let's assume that the process of adapting to the school has proceeded satisfactorily and the child is well ensconced into the classroom and is using the material, teachers, and the other children appropriately.

The pre-school child, as described above, is psychologically autonomous in that he has attained libidinal object constancy; has an identity; the ego has developed enormous synthesizing capacities and there is considerable separation of ego from id although this latter is not yet solid and can be readily breached. I am referring here to his capacity to distinguish fantasy from reality, to retain fairly consistent affect control, and to utilize secondary process thinking. His cognitive activities are those of discriminations of similarities and differences. On the drive side the child is at the phallic level of libidinal development and the aggressive drive is of a phallic thrusting type. On the developmental lines: he is self feeding, but with food still equalling mother; he is self sufficient as regards toileting although bowel and bladder control is not yet secondarily autonomous, so accidents may occur; he is highly egocentric and sees other children as threats to his object love and has little concern over property rights nor an altruistic wish to share; he considers his mother to be responsible for his dress, his health, and his comfort and pleasure; along the play line he is primarily at the level of ego activity play although imitation-identification play, exploratory play, and representational play are in evidence. The play behavior of such children reflects the above psychic situation and is of several varieties: First, one sees ego activity play. This is simply play behavior in which a known physiologic function is projected and displaced onto toys and materials. These are the opening and closing play; (that is of drawers and the like); the building up and knocking down (such as in block piling-stacking); the filling and emptying (with sand and water); and, there is also messing and cleaning up types of behavior. Another type of play that is very evident in the three year old is the imitation-identification type of play; that is, the imitating mother activities like cooking, setting the table, etc., father activities such as going to work, driving a car, fighting a fire, etc., baby activities such as sucking, rocking, going to bed; and the imitation of the wild beasts, monsters, and other scary things. As you know, the hand-claw gesture and the growl of the monster, tiger, wolf, or scary something is sufficient for a child of this age and in terms of the sense of reality it is the magic of thought, words and action. If the child tries to carry it beyond such gestures he loses the discrimination of fantasy from reality and has to restore his sense of reality by abandoning the play. We have often seen children imitate a tiger and this goes quite well. However, if he puts on a tiger suit you will find him becoming very upset and having to remove the suit. This is because the suit makes him feel as if he were indeed a tiger and had lost his sense of self. He has to quickly re-establish his sense of reality and sense of self by taking the tiger suit off. There is much "good" and "bad" role enactment—the good mother, the bad baby. In

fact, whenever we find that the child can play bad mother and bad baby as well as good mother and good baby then we have further evidence of the development of libidinal object constancy in such children with the needed amalgamation of good and bad into one object as opposed to keeping them separated. I am sure you are all familiar with this kind of play. It involves the child playing the role of baby and tossing the baby bottle out of the crib or buggy. Good mother patiently hands the bottle back to the child but the play baby child tosses it out again. Finally, the good mother becomes exasperated and calls the baby a bad baby. In these kinds of dramatic play we are witnessing the fusion of good and bad objects and self. The play of children of this age is primarily parallel. They do often play in pairs and take assigned roles in dramatic play but they tend to be perseverative and are not at the level of socio-dramatic play. The group behavior is what one might designate as a pre-group formation. They cannot function as a goal oriented group with an assigned task the group must do. They will be pre-group, however, in that they do behave in a parallel manner and one will see leaders emerge from one segment or the other of the group and the group may follow for very brief periods of time but it cannot be sustained. If such a group of three-year-old children were to attempt to act out and play out another child's dream they would be quite unable to do so inasmuch as role assignment would not be maintained and the dramatic play would break down very quickly. There is a good deal of exploratory type play in children of this age and the representational play including drawing, painting, work with clay and the like is mostly of an imitative identification type. One certainly sees the increasing sophistication of representational play in those children who use that form of play. For instance, one can see the development of the ability to represent the human figure increasingly evident in the child's art activities.

Usually by the spring of the first year in the nursery school the three-year-old class is a fascinating bunch of kids. They have learned many techniques for coping with the world. The egocentricity line has decreased in intensity and you will find them able to wait their turn and to share to a rather remarkable degree. Also, to have a reasonable amount of empathy for another child and his feelings. They self feed with utensils and one can readily see the food fads, the reaction formations of disgust and the changing of the food equals mother equation. The play line has developed beyond ego activity play and includes some pretty sophisticated dramatic play with capacities for sustained role enactment. However, socio-dramatic play is usually not present in the three year old. The cognitive line has developed remarkably and the discrimination capacities of these children is enormous. Reality and fantasy are strictly maintained and the world "pretend" is a favorite. Secondary process thinking is maintained most of the time. Finally boys are pretty satisfied to be boys and girls to be girls with opposite sex role "trying on" quite acceptable. In my opinion the girls are intensely involved in a triadic oedipal relationship whereas the boys remain dyadic.

The four-year-old group of children presents somewhat a different situation from the three year old. I think that teachers of four year olds, and perhaps especially boys, are dealing with the most difficult of the pre-school children. The greatest problem that the four year old encounters is his need for control of the

aggressive drive. This seems to be a good deal more of a problem in four year old boys than it is in girls. I have felt that most four-year-old girls were very deep into the triadic oedipal complex and aggression is less of a problem in those girls than we see in the boys. At the same time one will note that the striving for mastery and control is an important aspect of the four-year-old girl's development. I have felt that if one traces the aggressive drive in children one notes that in the beginning the aggressive drive is primitive, diffuse, undifferentiated, and directed both towards the self and towards the outside. Under the impact of the symbiosis the aggressive drive seems to be fused with the libidinal drive and is much more often directed towards mother's body rather than on their own body. As separation begins to occur the child is very apt to select a transitional object and the transitional object becomes the recipient of the aggressive drive. During the practicing phase of development the aggressive drive is primarily involved in the motor exploratory activities of the child while in rapprochement it remains fused with the libidinal drive. The ambivalence of the autonomy struggle represents the defusion of the drives and the relative ascendancy of the independent aggressive drive. During the phallic phase the aggressive drive has a thrusting quality to it and is a thrust towards discovering similarities and differences. However, at the four year level in boys (earlier in girls) reaction formations against the penetrative aggression of the phallic thrust are active and the triadic relationship of the oedipal complex appears. It appears to me that the fusion of the libidinal and aggressive drive is markedly lessened and the aggressive drive is of the order of an annihilative activity. This state of affairs leaves a child with a powerful, highly destructive aggressive drive which causes him a good deal of psychic distress. I see the separation from mother in the pre-oedipal dyadic sense, and the onset of the triadic oedipal relationship as an impetus for the defusion of libido and aggression. The felt annihilative potential of this drive is anxiety producing to the child and necessitates his developing techniques for control. It has become my belief that a specific ego apparatus for neutralization of this drive matures at this time and it is in that neutralization that the aggression proceeds from a world destructive type to the competitive type of aggression necessary for full development of the oedipal complex and its ultimate resolution. I, therefore, see the four-year-old boy as struggling very hard to gain a sense of control over his primitive aggressive drive. His play activity is then primarily that of control experimentation. One will see him build race tracks and run the car down the race track to the point of its falling off. He will build railroad tracks and run the train as rapidly as possible as if to see when it will fall off. He will build structures and see how high he can build them before they fall down. All of this involves his sense of control. It is my understanding, from my observations of these children, that only after they have gained a sense of control or feeling of mastery over that aggressive drive with a qualitative change from annihilative to competitive aggression will they then move into the triadic oedipal phase proper. At that point the libidinal drive is towards the mother and the competitive aggressive drive now is turned towards the father. This is certainly a new situation and requires and occupies the bulk of the late four year old's psychic energy. As is said before, the girl seems to me to have moved into this much earlier

than the boy and one will see a florid oedipal complex and triadic conflicts in a late three and early four-year-old girl. In my experiences most of the girls have done whatever resolution they are going to do of the oedipal complex by early five. Most of the boys are still struggling with this at middle five and only as they approach the 6th will they effect an adequate resolution of that complex.

To my mind, it is the movement from the dyadic situation of the pre-oedipal child into the triadic oedipal situation which accounts for the changes in behavior seen in the middle to late three-year-old girl and in the early four-year-old boy . . . specifically, it is the qualitative changes which the aggressive drive undergoes at that time. The play behavior of the children reflect those changes. I have grouped this play behavior under the word "control" to specify it as play activity which gains mastery and control of the aggressive drive and facilitates change from one of annihilative to one of competition.

Grouping is minimal at this time other than around the motor activities and the games of run and chase. Dramatic play in the four-year-old girls is along oedipal themes and they repeatedly seek a boy to take the role of the male husband or father . . . usually with poor results. Socio-dramatic play among the girls is quite possible and is again along oedipal lines. The boys are much more likely to be in pairs and to be seen constructing model race tracks, railroads, buildings and the like. Their dramatic play invariably relates to fires, policemen, accidents, hospitals, and injuries . . . dying and coming back to life. The magic of Superman, Batman, and the like are much in evidence. Towards the end of the fourth year the oedipal conflict seems to be all consuming and to see the various constellations and attempts at solution through play behavior is indeed fascinating. However, it is often surprising to note that specific areas of development proceed either because of the oedipal conflict or in spite of it. Motor skills and the concomitant synthesis of perceptual motor apparatuses proceed at a rapid rate. The eating line shows the definite influence of oedipal fantasies but with a further separation of food from mother. Reaction formations of disgust over anal impulses; shyness and modesty over exhibitionism; kindness over cruelty; sharing over greed, and egocentricity; and the like appear: albeit in evanescent form. The cognitive development continues unabated with the shades of differences becoming important as well as degrees of similarities. As effective control is gained, a sense of grouping occurs and the teacher feels a marked sense of relief and accomplishment.

The five-year-old group of children is characterized psychologically by the resolution of the triadic relationship of the oedipal complex and a return to a new type of dyadic relationships of increasing sophistication. There is increasing evidence of reaction formations against pre-genital strivings with more stability to this defense structure although regressions are frequent with earlier modes of drive behavior evident. There is increasing symbolic capacity and cognitive growth is profound, all under the influence of the oedipal conflict.

The play behavior of the five-year-old group is characterized by increasingly sophisticated socio-dramatic play. In this type of play, three or more children follow the lead of one in the "idea" and roles are assigned with each child elaborat-

ing his role as his own fantasy dictates but remaining within the assigned role. The creating of the scenario is the essence of the play and is the occasion for much fantasy material to appear. Props are obtained and the idea, dream or fantasy is carried to completion. Initially play disruptions are frequent and it is only through the facilitating role of the adult teacher that an idea can be carried to completion. However, near the end of the fifth year, the group can carry their ideas to completion without the assistance of the adult. Because of the increasing capacity to symbolize, abstractions become possible and the need for signs and thus word discrimination in its printed form is sought . . . the basis for reading readiness. The themes for the socio-dramatic play although obviously oedipal in the beginning of the year gradually become more disguised. The early themes are those of getting married and going on a honeymoon . . . the activities of the honeymoon remain an unplayed out mystery; having a baby; going on a date; and multiple variations of bedroom scenes. These give way to rescue fantasies at a fire or accident and full fledged hospital activities. Store play and classroom school play (as heard from an older sibling) are played out almost daily.

I would like to close my discussion of five year olds by telling you of a participant observation I made of two nearly six-year-old boys last May. Both of these boys had been playing word card games when I was invited to participate with them. Although the game itself was important to them, the need to know the various words on the cards and to be able to recognize them immediately was obviously important. When they tired of this game, they asked if I had a game to play. I chose a balance board about 12 inches long with sockets in it which were equidistant from each other and numbered from one to ten in this manner . . . zero was in the middle and marked the point at which the fulcrum was to be placed for balancing the board . . . to the left the numbers were one to ten and to the right were one to ten. There were a number of small, equal weights which fitted into the holes. I placed a weight at ten on the right and asked the child to put his weight so as to balance the board. He placed it at ten on the left. I moved the weight around to the various sockets on the right side and asked him to balance it on the left. Each boy did this successfully and with obvious pleasure. I then put a weight at eight and handed the one boy two weights to use on the other side to balance my side but he was not to use the same hole as mine on the right. He put one weight at three and the other weight at five and of course achieved the balance. The second boy put both weights onto four and achieved the balance. In neither instance was trial and error used. Each boy seemed to figure it out in his head. I then asked the first boy how he had figured it out. He replied that the weights were of the same size and weight and the holes were the same distance apart so he had figured that if he put one here and one there, it would balance. I asked the second boy how he had figured it out. He replied that four and four equals eight. When I tried to get the first boy to use the numbers and see that five plus three equals eight, he became anxious and soon began playing with the board as if it were a slide and used the weights to slide down the board. When I asked the other boy to see his answer in terms of distance from the center and in terms of the equality of the weights, he be-

came anxious and moved out of the play area. I made several such attempts to get each of the boys to understand what he had accomplished in the same terms the other boy had used. In each instance anxiety supervened and a disruption occurred with the result being a need on the boys' part to use the board and weight as a toy slide. Both of these boys had IQs in the 130 range and both were considered to be bright and competent—in many instances leaders of the group. The boy who used the concept of equal weights and equal distances had been known to me since his birth and I had followed his separation-individuation process and its recapitulation on entering nursery school. To my mind, he had been a most normal youngster in all respects. The second child, the one who knew that four plus four equalled eight was seen as a pseudo-mature child by me and his family had placed great emphasis on his learning to count, say the alphabet, read, and do his sums, and in all instances to be a "little man." The first child had come to an adequate solution to his oedipal conflict and was looking forward to beginning "real school." The second child was still actively involved in oedipal fantasies and seemed quite convinced of ultimate victory. He was excited about getting out of baby school and going to grown up school. Prediction in such instances is risky business but I have my money on the child who figured out from his own experiences that the weights being of equal weight and the holes of equal distance determined where one puts the weight to balance the other side. Once he learns his sums, it will have meaning to him. I can only hope that this kind of learning is not educated out of him.

THE EFFECT OF DRUG THERAPY ON LEARNING AND BEHAVIOR DISORDERED CHILDREN IN THE CLASSROOM: AN EXPLORATORY STUDY

Elizabeth Cheney, M.Ed. Landrum S. Tucker, Jr., M.D. Shirley Sanders, Ph.D.
Child Inpatient Unit
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Evaluation of change in classroom behavior is an important part of educational therapy for the child who has been emotionally unable to meet the demands placed upon him in the school setting. The program of the Child Psychiatry Inpatient Unit, a 9 bed short-term treatment center of the North Carolina Memorial Hospital, is structured to identify and to treat many of the variables that contribute to school failure. A multidisciplinary team approach has enabled our staff to see the complexity of problems contributing to poor school performance. The desire to more objectively evaluate classroom behavior and its improvement resulted in the present study.

The purpose of this study is to examine the effect of phenothiazines upon the classroom behavior of children who have been diagnosed as having behavior disorders, below normal intellectual functioning and/or learning problems. We also wanted to experiment with the behavior counting system presently in use and to test the practicality of Barbara Fish's descriptive classification of children's behavior disorders in relation to disruptive classroom behavior.

This study is exploratory in nature. It is hoped that knowledge gained will aid in the design of future classroom research.

The eight children included in the study were residents of the Child Psychiatry Inpatient Unit. Their ages range from 7 to 11 years. Each child is involved in both an individual and group therapy program on the Unit. The children attend school in a building adjoining the Unit for two and one-half hours each day. The purpose of the classroom program is to help the child learn to adapt to the demands of the school situation. Hence, an important part of the educational program involves evaluating student behavior. The teaching staff, however, found itself with no more than subjective feelings about each student's progress toward more acceptable behavior. It became obvious that a more objective means of evaluation was necessary. A system of behavior counting was developed which drew upon one used by David Phillips and reproduced in Becker's *An Empirical Basis for Change in Education*. The categories of behaviors counted appear in Table 1. Both appropriate and inappropriate behaviors are counted. Several categories of behavior are counted in either respect. These behaviors are: physical contact with another, orienting to others, and verbalizations. Negative behaviors are: hyperactivity (as characterized by Barbara Fish's term "rump hyperactivity"), disruptive noise, disturbing others, self stimulation, social withdrawal and out of seat. Other behaviors counted are task relevant behavior and teacher attention.

Behavior is counted in a time sampling procedure at 10 second intervals. Each child is observed for a one minute period five to eight times per day. Weekly counts are summarized and the ratio of negative behaviors over time provides an indicator of behavior progression.

The Child Inpatient Unit diagnoses behavior disorders according to Barbara Fish's descriptive typology. A nutshell description of these categories appears in Table 2. Generally, the types are separated according to the severity of defect in integrative functioning; Type I being more impaired than Type IV. Within each type symptoms may vary from severe (that is, psychotic) to mild. We use the term borderline to describe the child whose behavior reflects disturbance of ego function.

The medications used in this study are almost exclusively phenothiazines. Dosages are in the mild to moderate range of 50-150 mgm. The Unit is more objectively comparing the use of phenothiazines and stimulants in a study in progress at this time.

Procedure:

Data on the eight children identified was derived by averaging negative behavior counts for two week periods. The first two weeks the child was not on medications. During the second two weeks, medication was being administered. The point difference between the two averages was analyzed statistically for the total group. Comparisons of a more closely matched group were developed according to age, sex and medication administered. Three cases were eliminated from the original sample. More specific symptom patterns were identified for the remaining sample; including intellectual ability, perceptual-motor deficits, language processing ability, Electroencephlograms, behavior descriptors and a percentage change factor based on initial observation of behavior. In addition, change factors were derived through the same procedure for a group of children not on medication during a similar time period.

Lastly, precise problem behaviors presented by each child in the two diagnostic categories were identified. Percentage analysis was used to evaluate change for each behavior during phenothiazine therapy.

Results:

1. For the eight children studied there was a statistically significant change in behavior in the classroom during drug therapy. Significance was found at the .02 level. Change toward increased appropriate behavior was statistically significant at the .01 level. Table 3 presents data on the eight cases.

2. A group of children comparable in age and diagnostic category to the closely matched group but not receiving any medication showed little significant improvement in classroom behavior. During a similar time period (the first six weeks in school), the behavior of 3 of the 4 cases studied showed more rather than less disruptive behavior. Table 4 presents the data for these cases.

3. Examination of a more closely matched sample separated according to diagnostic category suggests a number of interesting trends. Variables identified

as important to classroom functioning are presented for each case in Table 5. In the matched sample, significant differences are observable between the cases diagnosed Type II, Immature-Labile and Type IV, Unsocialized Aggressive. Barbara Fish describes the Immature-Labile child as "characterized by immature and poorly integrated functioning in all areas". Her studies suggest that "the more impaired children of Types I and II . . . seem to have a higher incidence than Types III and IV of "soft" neurological signs (Fish 1971). The data in Table 5 supports this hypothesis. Cases diagnosed as Immature-Labile show more complex perceptual-motor deficits, language processing deficits as defined by the Illinois Test of Psycholinguistic Abilities, and more instances of abnormal EEG's.

4. The children diagnosed Type IV, Unsocialized Aggressive, showed a better response to phenothiazine therapy. The two cases averaged a 40% improvement in appropriate classroom behavior. Fish states, "The better organized child of Types III and IV is "most amenable to change by any therapy." (Fish 1971). The primary classroom problem is behavior of an aggressive, volatile or sexual nature.

5. The children diagnosed Type II, Immature-Labile did not respond to phenothiazine therapy as well as those diagnosed Type IV. The group averaged a 24% improvement in appropriate classroom behavior. For the children in this category, classroom functioning was complicated by integrative deficits; complex perceptual-motor problems, inadequate language processing and abnormal EEG's. Behavior was hyperactive, bizarre and socially inappropriate.

6. Both Mellaril and Thorazine were used in the 5 cases compared. The difference in effectiveness of the two drugs was not significant. Change toward improved behavior averaged 29% for Thorazine and 35% for Mellaril.

7. The precise problem behaviors presented by cases from both categories support the descriptive typology defined by Fish. The Unsocialized Aggressive showed clearly patterned behavior marked by anti-social tendencies. The Immature-Labile showed highly functioning marked by impulsive and provocative behaviors. Table 6 presents the problem behaviors observed for the two groups. The behaviors that appear reflect different patterns.

8. Trends of change during phenothiazine therapy are observable for the group as a whole and in relation to diagnostic categories. Table 7 presents these behaviors and the direction of the change; plus indicating a proportionate increase and minus a proportionate and absolute decrease.

A. Certain behaviors *Decreased* both in absolute counts and proportionately.

- (1) In 4 of the 5 cases *hyperactivity* appeared as a problem behavior, in 75% of these cases it decreased.
- (2) In 4 of the 5 cases *self stimulation* appeared as a problem behavior, in 50% of these cases it decreased.
- (3) In 2 of the 5 cases, *distraction* appeared as a problem behavior, in 100% of the cases it decreased.

B. Certain behaviors *Increased* as a proportion of total negative counts.

- (1) In 3 of the 5 cases *negative verbalizations* appeared as a problem behavior, in 100% of these cases it increased.

- (2) In 3 of the 5 cases *disturbing others* appeared as a problem behavior, in 100% of the cases it increased.

Significant changes for those cases diagnosed Type IV, Unsocialized Aggressive are as follows:

- (1) In both cases *negative verbalizations* and *disturbing others* INCREASED as a proportion of total negative counts.
- (2) In both cases *self stimulation* DECREASED in absolute counts and proportionately.
- (3) In both cases *social withdrawal* appeared as a problem behavior *only* during phenothiazine therapy.

Significant changes for those cases diagnosed Type II, Immature-Labile are as follows:

- (1) In 2 of the 3 cases, *negative physical contact* appeared as a problem behavior, in 100% of these cases it DECREASED both in absolute counts and proportionately.
- (2) Where it appeared, *self stimulation*, *disruptive noise* and/or *out of seat* behavior INCREASED as a proportion of total negative counts.

The above changes are significant based upon non-parametric analysis.

Conclusions:

Phenothiazine therapy improved the classroom behavior of the children studied. There is a difference, however, in the way children responded to medication. Children diagnosed Type IV, Unsocialized Aggressive have less integrative deficits and respond better to medication. Children diagnosed Type II, Immature-Labile do not respond as well and show more "soft" neurological signs.

The behavior counting system appears to be a useful scale for evaluating classroom behavior and the effects of medication. Phenothiazine therapy results generally in significant improvement for classroom behaviors defined as *hyperactive*, *distractible*, and *self stimulation*. If *negative verbalizations* appear as a problem behavior, they increase proportionately during medication. Treatment factors in addition to medication may be related to this increase. Other research suggests a similar increase in verbalizations (Werry *et al.*, 1966). If attention seeking from peers is a problem behavior, it is maintained and increases in proportion to total negative counts. The Unsocialized Aggressive child becomes more socially withdrawn during phenothiazine therapy while the Immature-Labile child maintains certain impulsive-attention seeking behaviors.

There appears to be no significant difference between the two medications (Mellaril and Thorazine) in terms of improved appropriate classroom behavior.

Summary:

The following points should be made as a summary of our study:

1. Phenothiazones in mild to moderate dosage decrease hyperactivity and distractibility in children with severe behavior disorders.
2. It is our impression that medication gives such children the advantage of being able to "tune in" better to classroom tasks and activities.
3. As certain behaviors decrease, other behaviors increase in proportion to total negative counts. In many cases this change shows improvement. When Billy

slams down a book in anger rather than hitting or shoving a peer, we can see that progress toward more acceptable behavior has been made.

4. The behavior counting scale is useful in looking at discreet behaviors. It appears to be consistent with Barbara Fish's descriptions of behavior specified for the diagnostic categories, Unsocialized Aggressive and Immature-Labile.

5. Fish's categories of behavior do distinguish separate groups as measured by behaviors observed in the classroom, response to medication, and the extent of learning deficits.

TABLE 1
CLASSROOM BEHAVIOR CODE

- = PHYSICAL CONTACT WITH ANOTHER
 - + Touching affectionately, holding hands
 - Hitting, shoving, striking with hands or object
- = ORIENTING TO OTHERS
 - + Listening or attending appropriately to peer, teacher, etc.
 - Distracted by things occurring in classroom
- = VERBALIZATIONS
 - + Speaking appropriately (situation and content)
 - Speaking out at inappropriate time and/or with inappropriate content (cursing, defiance, etc.)
- = HYPERACTIVITY (DISRUPTIVE WITHOUT NOISE)
 - Rocking in chair, arm waving, dancing or gesturing with body
- = DISRUPTIVE NOISE
 - Tapping pencil, slamming down book, tearing paper
- = DISTURBING OTHERS
 - Pushing, poking, teasing (faces or gestures) grabbing or destroying other's property
- = SELF-STIMULATION
 - Daydreaming, autistic-like preoccupation
- = SOCIAL WITHDRAWAL
 - Refusal to participate, unawareness of classroom activities
- = OUT OF SEAT
 - Without permission, aimless wandering
- = APPROPRIATE BEHAVIOR FOR TASK
- = TEACHER ATTENDING OR RESPONDING TO CHILD
- = CHILD NOT OBSERVABLE FOR COUNTING
 - (Bathroom, outside classroom)
- = CHILD REMOVED FROM CLASSROOM SITUATION TO "SETTLE DOWN"

TABLE 2

SUMMARY OF DIAGNOSTIC CATEGORIES (FISH, 1971)

- I. AUTISTIC DISJUNCTIVE: Schizophrenoid, different, bizarre, incoherent
- II. IMMATURE-LABILE: Hyperkinetic, poorly integrated, labile, distractible
- III. ANXIOUS-NEUROTIC: Withdrawing, "nice", fearful
- IV. UNSOCIALIZED-AGGRESSIVE: Bossy, bully, angry, manipulative

TABLE 3

<i>Name</i>	<i>Age</i>	<i>Sex</i>	<i>Race</i>	<i>Diagnosis</i>	<i>Medication</i>	<i>Change Factor</i>
J	11	M	W	TYPE II	RITALIN	—38%
R	11	M	W	TYPE II	THORAZINE	7%
F	9	M	W	TYPE II	MELLARIL	21%
T	10	M	B	TYPE II	MELLARIL	45%
M	11	F	W	TYPE II	MELLARIL	70%
D	7	M	W	TYPE II	THORAZINE	34%
W	10	M	B	TYPE IV	MELLARIL	30%
E	9	M	B	TYPE IV	THORAZINE	50%

TABLE 4

<i>Name</i>	<i>Age</i>	<i>Sex</i>	<i>Race</i>	<i>Diagnosis</i>	<i>Change Factor</i>
B	9	M	W	TYPE IV	—117%
M	8	M	W	TYPE II	—133%
G	10	M	B	TYPE IV	+29%
W	11	M	W	TYPE IV	—31%

TABLE 5

Name	Age	Race	Diagnosis	IQ	Language			Medication	Behavior	Change Factor
					P-M Deficit	Processing	EEG			
W	10	B	Type IV	76	Visual Form & Space (Mild)		Normal	Mellaril	Aggressive Bully	30%
			Unsocialized Aggressive	V-91 P-64					Omnipotent Explosive	
E	9	B	Type IV	92	Visual Form & Space (Moderate)		Normal	Thorazine	Aggressive Volatile Sexual	50%
			Unsocialized Aggressive	V-85 P-101						
D	9	W	Type II	96	Coordination & Balance (Mild)	Deficit	Abnormal	Mellaril	Hyperactive Manipulative Pest	21%
			Immature-Labile	V-97 P-96	Visual Form & Space (Mild)					
			Borderline							
T	10	B	Type II	75	Coordination & Balance (Moderate)	Deficit	Abnormal	Mellaril	Hyperactive Bizarre Anxious Socially Inappropriate	45%
			Immature-Labile	V-72 P-82						
			Borderline		Visual Form & Space (Moderate)					
R	11	W	Type II	83	Visual Form & Space (Mild)	Deficit		Thorazine	Hyperactive Bizarre Sexual Socially Inappropriate	7%
			Immature-Labile	V-80 P-89						
			Borderline							

TABLE 6

Hyper-activity	-Verbalizations	Distractible	Self Stimulation	Disturbing Others	Social Withdrawal	Out of Seat	Disruptive Noise	-Physical Contact	Type 4
W	✓	✓	✓	✓	✓				
E	✓		✓	✓	✓				
D	✓		✓			✓	✓	✓	Type 2
T	✓	✓	✓			✓	✓		
R	✓		✓			✓			

TABLE 7

Hyper-activity	-Verbalizations	Distractible	Self Stimulation	Disturbing Others	Social Withdrawal	Out of Seat	Disruptive Noise	-Physical Contact	Type 4
W	—	+	—	+	+				
E	+	+	—	+	+				
D	+		—			—	+	—	Type 2
T	—		—	+		+	+	—	
R	—	+	+			+			

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A CLINICAL NOTE ON PATIENTS EXHIBITING ACADEMIC UNDERACHIEVEMENT

Jerry B. Saffer, Ph.D.
University of Virginia Medical Center
Charlottesville, Virginia

Kenneth A. Naylor, M.D.
Dorothea Dix Hospital
Raleigh, North Carolina

School underachievement is a recalcitrant problem which often makes up a major portion of a child psychotherapist's practice. In fact, Gilbert (1957) suggested that underachievement represents the single most frequent reason for referral. Kessler (1966) writes that under achievement is one of the most often written about subjects in mental health literature. It is a problem area which is certainly irritating to the parents and discouraging to therapists, especially when the problem is seen at its extreme, that is, youngsters with superior cognitive potential who are near the bottom of their class and who have, in fact, experienced several failures. It is difficult for the therapist to be empathic with these patients, for he, as a professional with an advanced degree, is often himself the product of appropriate academic over achievement which has been attained at the expense of many other facets of his life.

Review of Literature

Before describing a phenomenon observed by the authors in the treatment of neurotic learning disordered children, a brief discussion will be presented of some of the clinical findings of others interested in these patients. This review will be limited to neurotic learning disorders in which cognitive subnormality and/or organic factors have been ruled out.

Underachievement is found with seven times greater frequency in boys than in girls and is most often seen in boys of the lower socioeconomic class (Harris, 1961). Familiarly, as in many psychopathologies, father is posited as weak, of low self-esteem and feeling himself to be a vocational failure (Grunebaum, 1962). According to Hall (1966), these fathers are seen by their spouses as ineffectual and dependent, yet are also angry and disapproving. A frequent and striking complaint voiced by these wives is that their husbands are most disapproving of the relationship which these mothers have effected with their sons. The husbands criticisms are felt to be destructive and grossly unfair and are usually countered by the claim that the fathers have psychologically absented themselves from their families and consequently forced the mothers into an all encompassing parent role. The mothers often work and feel they are carrying a double burden as the working and main parenting figure. Marital discord is characteristic, and to quote Harris (1961), "mothers of non-learners lack the ability to integrate their ambitiousness into a larger scheme and to subordinate it to family goals".

The children have been described as frightened and unable to become comfortable either in an active or passive role within the family (Sperry, 1958). They are usually last born children and appear to be in need of, and constantly searching for, emotional nurturance. They lack flexibility as family members and seem unable to take a dominant role when appropriate, or to act dependently when

that is expected. They appear to easily trade independence for dependence and their dependent position is frequently masked by a somewhat pseudomature stance.

Their underachievement has also been described as an attempt to remain anxiety free by being as knowledgeable as possible. Knowledge is seen as dangerous since it can eventually bring to the fore upsetting erotic and aggressive material (Klein, 1945). Sperry (1952), has suggested that material which is difficult for neurotic children to learn is that which is akin to their phantasy life. They attempt to constrict their intellectual life either by obsequiousness or by pronounced aggressivity, and it has been suggested that the submissive non-learner is the child who most seriously constricts his ability to learn (Sontag, 1955).

Clinical Description

The phenomenon to be described was observed among a series of ten patients, all boys, seen at the Division of Child and Adolescent Psychiatry, University of Virginia Hospital. Their ages ranged from seven to ten years and they were referred to the Clinic mainly because of poor school performance. The parents initiated the contact most often after they had asked either a teacher or pediatrician how best to deal with their child's learning difficulties. The children were seen for a series of play interviews and were also administered a psychological test battery consisting of cognitive, perceptual and projective tests. The parents were seen for three interview sessions each of approximately one hour. Cognitively each child showed himself to be at least in the bright normal I.Q. range and several were in the superior range. In accordance with the findings of Bond and Fay (1950), most of the underachievers scored at least seven points higher on the performance subtests than on the verbal subtests of the Wechsler Intelligence Scale for Children. Three of them had twenty point spreads in the above stated direction, and none of the patients showed evidence of a perceptual handicap. Because of their lack of academic accomplishments, fairly complete perceptual testing was undertaken and this included the Bender Gestalt Test, Frostig Developmental Test of Visual Perception and Raven's Progressive Matrix Test. The organic indicators of the Human Figure Drawings were also considered, and many were given the Illinois Test of Psycholinguistic Abilities.

Projective material revealed highly anxious neurotic youngsters, each of whose protocols showed marked emotional and intellectual constriction. Each of them gave many fewer Rorschach responses than expected of a child of his age and intelligence, and all of them gave unoriginal, regressed and stereotyped responses. Thematic material was of a dependent and passive nature. As a group, these children appear to shun competition with both peers and siblings.

Following the diagnostic evaluation, each child was placed in individual psychotherapy on a one time a week basis, and many of them were later placed in play therapy groups, usually after ten to fifteen sessions of individual therapy. The parents were seen at two weekly intervals for counseling, and it was noticeable that they were highly motivated to be of help to their sons, with the result that very few sessions were missed by either parent or child.

A most striking phenomenon in each of these underachievers was his extreme discomfort at the experience of being alone. With each patient a sequence occurred during the process of psychotherapy during which an angry verbalization, usually somewhat tenuous towards a parent, was directly followed by either a play or verbal sequence in which the child described episodes in his life when he had been left to fend for himself. For example, A., age 10, with an I.Q. of 110, produced the following sequence: after about ten psychotherapy sessions, he made the first negative statement about his parents, and then turned to the play stove where he began to cook a meal. While doing this, he talked continuously about his frequently absent mother, who in fact, is seldom absent at mealtimes. Although his mother works during school hours, she is usually home in time to prepare meals. A. showed an almost phobic dread that he would be left alone, and he was able to connect that his fear of being left alone might be the consequence of his angry feelings. A. well demonstrates the tragedy of the underachiever in that he is handsome, intelligent and well coordinated. Nevertheless, he is the low man on the aggressive totem pole, in spite of the fact that he is the oldest and largest of his siblings. He spends time alone only when he tires of abuse given by these siblings. B., age seven, with an I.Q. in the Superior range, was failing when referred for evaluation. He also demonstrated these patients' association of anger and isolation. His verbal outbursts in group therapy were followed by concern that his therapy mate would not be able to attend the next session even though B's anger was not directed towards the other child.

The underachievement problems of A. and B. has taken different forms in that while A. is able to learn but is unable to produce under examination pressure. B. is so preoccupied with an ingratiating stance that he is incapable of applying himself for the original learning.

Discussion

These patients difficulty with aloneness appears to be directly related to their academic underachievement. Disciplined academic work requires the student to heighten his own stimulus barrier and to produce a self-initiated and self-sustained state of isolation. The child must opt for task oriented isolation in lieu of social interaction. These neurotic children seem to be incapable of this and their failure to produce in school assures them of the teacher's attention and wrath since they work only when closely supervised by the teacher. When he moves on to the next child, these patients try by various means to attract his attention and thereby avoid being left alone. Teachers reports were filled with the same discouragements as were the parent interviews.

The same masochistic but highly social mechanism pertained in the underachievers failure to do homework thereby assuring constant parental attention. Homework produced continuous interaction between the parent and child, which in some homes began minutes after the child arrived from school. To quote Irving Harris (1961), homework required the characteristics of an "educational tug-of-war". In fact, the essence of parent counseling in these cases is to ensure parental understanding of the fact that the homework belongs to the child and is not a joint intellectual and social interaction. Even though these parents are highly

motivated to help their children, they find it difficult to give up this domination. They often feel frustrated as they sense that their child's future is being limited because of his poor school performance. They also have the additional frustration of the realization that their attempts to help have been fruitless as evidenced by the child's failure to improve his performance. In working with these parents, it is important to deal with their feelings of desperation and frustration at their child's lack of progress, in addition to helping them develop an understanding of the role the child is enticing them to assume by his own failure to produce. They characteristically see their child's poor grades as a reflection of themselves.

It is interesting to speculate as to what isolation means for these young patients. It appears that for some this is the nature retribution. For C., age 10 years with his superior I.Q. and "C's" and "D's" in school, isolation was the convincing experience that his parents did not love him. He completely filled the therapy hour with his conversation and would become upset if the therapist remained silent during any part of the hour. In these silent periods he would project his feelings of hostility and would frequently break the silence by describing aggressive acts of other children which had been directed towards him, or would make statements of irritation at the diagnostitian, who he accused of not talking to him because he, that is the therapist, did not like him. When C. discovered silence meant to him isolation, the same isolation he left during work periods at school, he was able to significantly improve his academic performance.

Other patients were able to admit that silence made them uncomfortable because they experienced feelings and thoughts which they did not like. Further probing during psychotherapy revealed the fact that the thoughts which came to the fore during silent periods were usually aggressive in nature. D., age 7 years, who had failed first grade despite average intellectual skills, would often break his own silence with heightened motoric activity which included slamming a ball against the playroom wall.

When this type of neurotic patient is placed in group therapy, he initially protests about the intrusion of other group members, but these protestations are easily recognizable as a facade. Interaction with other group members is usually good. But when another group member absents himself, the patient does not luxuriate in the heightened attention of the therapist, but remains concerned about being left. His sense of isolation is piqued, and in several instances it was at this point that the child's fear of isolation became clearly exhibited, and his academic inability could be interpreted as his dread of solitude. This type of neurotic patient can be described as unconsciously undertaking almost any maneuver to avoid isolation.

In summary, this paper describes a variable which appears to be important in understanding and treating neurotic learning disabilities. It is promising that with these children, the problem of isolation was identified and there was marked improvement in school performance following psychotherapeutic intervention.

Further research in this area is needed to determine how pervasively this variable occurs in children demonstrating the problem of neurotically based learning disabilities.

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A MODEL FOR THERAPUTIC RAPPORT

Richard Weiner, M.D.
Department of Psychiatry
University of North Carolina
Chapel Hill, North Carolina

An increasing tendency to seek help for emotional distress has created an extraordinary demand upon existing mental health resources. In response to this demand there has been both a quantitative increase and a qualitative diversification of mental health services. A myriad of therapies resembling each other on the surface only in terms of their claims for success now exist. At the same time relatively little attention has been given to the "process" of therapy for emotional problems. Perhaps therapy has become as Torrey (1972) puts it, "like toothpaste," with great amounts of energy expended in promoting particular brands and very little energy left over for finding out what really works and why.

This paper will attempt to describe a model for what I feel is the most important common denominator among the various psychotherapies—therapeutic rapport. In their *Psychiatric Dictionary*, Hinsie and Campbell defined rapport as:

"The existence of a mutual responsiveness such that every member responds immediately, spontaneously and sympathetically to the sentiments and attitudes of every other member."

For a definition of "therapeutic" rapport I will suggest the following: a therapeutic rapport exists when a patient becomes affectively aware of being empathically understood by a therapist. Inherent in this definition are three separate types of phenomena: communication, cognitive perception and empathic understanding. By this I mean that for therapeutic rapport to exist, the therapeutic dyad must communicate with one another, must perceive communication in a cognitive fashion, and must achieve either an empathic understanding or an awareness of being empathically understood based on this communication. In order to develop a model for how therapeutic rapport operates, we shall focus on the flow of information between a patient and therapist and what happens to this information. First, however, I shall briefly mention some of the other common denominators shared by the various psychotherapies.

Essentially, the factors common to all psychotherapy can be divided into two separate areas: intrinsic and extrinsic. Intrinsic factors are those which arise out of the personalities of the patient and the therapist and the relationship they share together and are independent of therapeutic technique. Therapeutic rapport is such a factor; others include hope, expectation of change, trust, and emotional arousal. The literature contains many attempts to elucidate the intrinsic factors common to and necessary for meaningful psychotherapeutic change. The work of Rogers (1957), Truax, et al (1965), Frank (1973, 1974), Strupp (1973a), Torrey (1972) is particularly noteworthy, but will not be reviewed here. Extrinsic factors are those which are dependent on the psychotherapeutic technique itself, irrespective of the therapeutic relationship. One such set of factors are the ways

in which the patient's problems are formulated. This varies widely, from the psychodynamic framework of psychoanalysis to the sharply defined focus on overt behavior as in behavior modification. Other extrinsic factors relate to treatment goals, e.g., a narrow goal orientation vs. open-ended management, short-term vs. long-term work, supportive vs. insight oriented therapy. A final set of extrinsic factors have to do with the style in which the therapeutic interactions are carried out. This ranges from the maintained neutrality of the analytic and Rogerian schools, to the direct confrontation involved in Gestalt, rational and emotive therapies. Precisely where to draw the line between what is due to intrinsic and what is due to extrinsic factors is usually far from obvious, and such a differentiation has evoked numerous controversies, e.g., Garfield (1973), Strupp (1973b).

A common error in both theory and clinical practice alike, in fact, is to assume that a given type of therapeutic interaction is either intrinsically or extrinsically "pure". I think we can safely assume that nothing in life is pure. What is clear is that intrinsic factors are the medium through which extrinsic factors operate. Without either a personality for the patient and the therapist or any sort of therapeutic relationship, any therapeutic technique would be exceedingly unlikely to be successful. For therapy to be successful, we must have first a patient who:

- (1) is beset with certain dysphoric feelings which compromise the quality of his or her life.
- (2) has a balance of interpsychic forces directed towards an adaptive resolution in the conflicted areas.
- (3) has a realistic hope that his or her dealings with the therapist will allow such resolution to occur.

In addition we must have a therapist who, through the use of a combination of the intrinsic and extrinsic factors described above, is able to mobilize the patient's hope and desire for change in such a way that therapeutic success is achieved.

Now let us begin with our model of therapeutic rapport. We shall first look at the information transmitted from patient to therapist. The mode of this transmission may be verbal or non-verbal, its origin may be conscious, pre-conscious or unconscious. It is accompanied by varying type and intensity of affect, and its basic content may be simple or complex. What factors affect what, how, and when the patient shares his or her thoughts and feelings with the therapist?

First, as previously mentioned the patient must be motivated by a sincere desire for change and an adult appropriate hope that the therapist will help such change to occur. Without these there exists no drive towards therapeutic change. Another factor which directly influences the communicative process is the nature of the ongoing relationship between the patient and the therapist. Friedman (1969) has suggested that a therapeutic alliance may manifest the following transference phenomena "a. the mature transference derived from . . . need for guidance; b. the tender part of the erotic transference; c. the primordial transference from the wish for the nurturing body contact of the mother as the driving force."

Although motivating factors and positive transference help the patient to share his or her thoughts and feelings with the therapist; anxiety and negative feelings, both objective and transference-bound, hamper this process. Often the negative side of this balance is the stronger, and a psychologic resistance, or unconscious opposition, by the patient is the result. Functionally, in terms of our model, this represents a barrier to communication. In addition, a high level of anxiety may evoke an intensification in intrapsychic defenses, often leading to a regression toward more primitive defenses and coping mechanisms which also serve to limit the scope of the information flow. This in itself is not necessarily anti-therapeutic. Sometimes, as with supportive cases, or where there are very limited and clearly defined goals, or when the conflict between opposing forces becomes too intense, the therapist finds him or herself needing to bolster such defenses. The troubled, alienated author, Franz Kafka, was probably in touch with such a conflict when he wrote in his diaries: "this tremendous universe that I have in my head—but how can I free myself and set it free without being torn to pieces?"

Another consideration in terms of what the patient shares with the therapist is the role of what has, is, and is expected to be happening outside of the therapeutic contact. A therapeutic interaction is far from being a closed system. The patient's (but, of course, also the therapist's) present motivation state, feeling tone, level of emotional arousal, cognitive functioning, and the scope of his or her conscious awareness are all affected by the "outside world."

Having discussed the communication of information from patient to therapist we now need to consider how the therapist receives it, combines it with his or her ongoing cognitive formulation and affective "feel" for the patient, and then understands it. Studies by Rogers (1957), Truax, *et al* (1965), Frank (1973), and others have stressed the importance of empathic understanding vs. mere cognitive understanding in terms of therapeutic outcome. Frank (1973) and Torrey (1972), among others, have found that the significance of empathy in psychotherapy is invariant not only with respect to different therapeutic techniques but also with respect to different cultures. In other words, the reliance, knowingly or unwittingly, upon empathy for a highly educated psychiatrist might not be markedly different from that for a mask-wearing, rattle-shaking witchdoctor.

The *Psychiatric Dictionary* defines empathy as:

"putting oneself into the psychological frame of reference of another so that the other person's thinking, feeling, and acting are understood and to some extent predictable— . . . the ability to accompany another to wherever the other person's feelings lead him no matter how strong, deep, destructive or abnormal they may seem."

From the psychoanalytic literature, it is felt that empathy, if it is to be therapeutic, must be transient, that the therapist must maintain a certain degree of object distance from the patient, and that a good deal of cognitive processing in addition to an immediate affective response is required. A fixed identification with the patient would compromise the objectivity of the therapy. Beres and Arlow (1974) mentioned in this regard that:

"the therapeutic situation requires that empathy and intuition go on to interpretation and insight, otherwise we would have no more than a mutuality of experience—for the patient a transference experience and for the therapist a countertransference experience."

Shapiro (1974) has recently pointed out a number of the ways that empathic-like phenomena may actually be manifestations of defenses. These are described as countertransference phenomena in which the appropriate object distance from the patient is lost and the therapist experiences a transient regressive merging with the patient in which there is a projection of the therapist's affective state onto the patient. This may be not unlike what we call "sympathy," in which we are unable to differentiate between our own feelings and those of the other person.

The relative importance of affective and cognitive substates in the formation of empathy is an intriguing issue. One major difficulty in separating the two is that the therapist's empathic understanding appears to be based on both conscious and unconscious mechanisms [Beres and Arlow (1974)]. Clearly a certain amount of cognitive processing needs to occur, otherwise we would not be aware of what we were being empathic towards. Empathy without affect is equally untenable, because this would entail being able to "feel" cognition.

A great deal of interest has been devoted to the question of why some therapists are more "empathic" than others. What makes them so? It certainly doesn't appear to develop through academic training. Rogers (1957) has said that

"intellectual training and the acquisition of information has, I believe, many valuable results but becoming a therapist is not one of them."

Torrey (1972) adds that

"those genuine, warm, empathic therapists who do emerge may do so in spite of, not, because of the system of selection."

Although far from adequately understood, the ability to empathize seems to be a personality trait rather than a learned behavior. This does not mean that one's empathic potential is fixed, however. We might expect that, at least theoretically, this potential would be maximized by well supervised therapeutic experience. Also, for any given therapist, the amount of empathy may vary from patient to patient, and from moment to moment in the case of a given patient.

Studies of transcultural psychotherapy have shown that sociocultural differences may make empathic understanding difficult even when language barriers are not present. Similarly, the information conveyed by psychotic or severely retarded patients may be difficult to understand and therefore to empathize with. It may be difficult to empathize with patients whose resistance places barriers in the path of effective communication, e.g., those who hold back information or who seek to deny or grossly distort it. Unfortunately a number of countertransference issues also affect empathy. These include the patient's age, sex, occupation, attractiveness, mannerisms, even smell, the nature of his or her problems, and moral issues brought up by the patient's situation. Freud expounded on this in his and Breuer's *Studies on Hysteria* (1955)

"I cannot imagine bringing myself to delve into the psychical mechanisms of a hysteria in anyone who struck me as low minded and repellent and who on closer acquaintance would not be capable of arousing human sympathy."

We must also not forget that the attention of the therapist may be tuned in directions other than toward the patient and that countertransference feelings may modify not just the empathic response but also the cognitive reception of the information.

All of the above factors affect how well a therapist can empathize in a given therapeutic situation. Some therapists recognize that they empathize particularly well or poorly with various types of patients. They may react to this by making an effort to compensate for the imbalance, or they may decide to use this information to decide which patients to accept.

Eventually, if the therapist's empathy is to have any effect upon the patient, it must be communicated to him or her. All the empathy in the world will not be enough if the patient does not know it is there. The timing, form, and content of the communication of empathy is determined by a combination of intrinsic and extrinsic factors which have already been described. Therapeutic technique has great importance here. The psychoanalytic therapist, for example may consciously delay such communication for prolonged periods, but its effect, when finally released, may be quite profound. A more directive, experientially inclined therapist may go out of his or her way to impress his empathic feelings on the patient. While on the surface this might appear beneficial, in practice there is the danger that the patient could either become dependent upon such affective feedback, or, on the other hand, become tolerant to its effect, so that it loses its significance. In general, the communication of empathic understanding is most effective when it conveys a sense of nonpossessive warmth, dedication, interest, trust, respect, genuineness and an optimistic outlook [Rogers (1957), Frank (1973), and Green-son (1972)]. An example of such communication, taken from the Leighton's (1941) work with the Navajo follows:

"if an Indian is told to take digitalis every day, he will probably munch a few tablets and then forget about them. If he is told that this green medicine comes from the foxglove, that his body must never be without it anymore than his mind is without a good song, and that he must take it every morning of his life when the first brightness of the day is in the East, one stands a much better chance of having the instruction carried out."

Ideally, each time the therapist responds in such a manner as described above the patient will become more aware that he or she is being understood and, if maintained, this will lead to a strengthening of the therapeutic alliance and a greater opportunity for therapeutic change. The level of empathic acceptance by the patient depends on a number of factors. First there are socio-cultural and language differences which may present a problem. Just as therapists vary as to their ability to empathize, we might well expect patients to vary in their ability

to accept an empathic response. As with the therapist, this predisposition would probably reflect the personality structure. The patient's ability to cognitively perceive and assess information is also involved. The psychotic or mentally retarded patient may have special difficulty with this. Similarly, the type and level of emotional arousal being experienced by the patient exerts an effect. The angry patient, for example, might well have a hard time relating to an empathic response by the therapist. The status of the therapeutic relationship is very important. A patient who has developed a strong alliance with the therapist will tend to be more accepting, although transient negative feelings toward therapy and/or the therapist may well temporarily remove this advantage. Finally there are the effects of what is going on in the patient's life outside of therapy. The patient who is presently exposed to a high degree of external stress could prove either more or less able to relate to his or her therapist's empathy.

In many cases, the sum total of the above effects will present such a barrier that even though the therapist will have empathized with, and will have communicated the empathic content to the patient, it is not perceived. If this barrier appears to be insurmountable, a switch in therapist, or at least in the way in which information is being communicated may be indicated.

The awareness of the patient that he or she is being understood, with all the reality and transference implications of such a process, is similar to empathic understanding itself. Yet it is more than just empathy because it implies a mutuality that is not present with empathy alone. The name we have given for this phenomenon is "therapeutic rapport." The development and maintenance of therapeutic rapport is an integral part of the therapeutic alliance and whatever goals are achieved by its use. The model of therapeutic rapport developed throughout the body of this paper represents a simple phenomenon logic described of the actual process. Although this model consists of discrete steps, therapy itself is not a discrete, but rather a continuous process, and it must be understood that in an actual situation any or even all steps may be operational simultaneously. In summary, this model consists of four stages:

- (1) a "patient" who needs and wants to experience relief from dysphoric feelings, communicates information regarding this to a "therapist."
- (2) The therapist accepts this information, integrates it with previous received information and arrives at an accurate empathic understanding.
- (3) The therapist communicates this empathic understanding along with a sense of nonpossessive warmth, respect, genuineness and optimistic outlook to the patient.
- (4) The patient accepts this information, integrates it with his or her present cognitive and emotional set and arrives at an empathic sense of being understood.

Before ending let me give a short clinical example in order to demonstrate certain elements of the above model for therapeutic rapport.

A patient is 15 minutes late to his therapy session. He is not aware of having a "good reason." He is, however, enough in touch with his feelings about being late that he experiences a steadily mounting sense of anxiety, guilt, and apprehension as he enters the door of his therapist's office. The therapist, more impressed by the emotional turmoil he observes than by the fact that the patient was late, says "You seem upset, I wonder what is bothering you?" This remark makes the patient feel worse and he becomes furious. For a moment he remains silent but then expresses his anger to the therapist, who then realizes his own mistake.

In looking at this example from the perspective of our model, we first are aware of a strong, non-verbal, affectively loaded message being communicated to the therapist. The therapist's response shows that he has at least some superficial cognitive understanding of this message. We have no way of knowing, however, whether this understanding has any empathic content to it. What is more important is that the patient does not know this either. The patient quite naturally feels that if the therapist "really understood" him, the therapist would have let him know, i.e., would have made an empathic response. Overcome with anxiety and guilt, the patient assumes the worst: "He doesn't know how I feel, he doesn't care about me, etc." This is evidence of a lack of therapeutic rapport and results in the formation of a transient barrier to further communication from the patient. Yet before long, unknown factors, possibly motivational in origin or perhaps on the basis of a reasonably strong ongoing therapeutic alliance, somehow provide the impetus for the patient to overcome this barrier and for the therapeutic work to continue.

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AGRICULTURE: A UNIQUE MODALITY FOR INPATIENT TREATMENT

Joni Linick Grant, Ph.D.
Grant Center, Inc.
Miami, Florida

Introduction

The acts of planting, nurturing, and harvesting, opens the door for bringing children with hitherto limited horizons closer to life in tangible terms. The orderly sequential development of plant life, as seen in the Grant Center nursery, brings to reality the phases of their own development. The agriculture program in its entirety, helps the overall program of emotionally ill children in a number of ways. The establishment of controls, ego boundaries, and reality testing, are but a few of the great benefits seen during the first two years of the program.

Setting and Population

This program is being conducted at the Grant Center, located on 20 acres in rural Dade County, the southernmost tip of greater Miami, Florida. As a psychiatric treatment center—hospital for children and adolescents, Grant Center has traditionally treated acute and chronic cases of mental illness, including such diagnoses as psychosis adjustment reaction of adolescence, severe personality disorder, mild mental retardation with psychoses, and organic brain syndrome with psychosis.

The children are basically from seven to seventeen years of age, although children younger and older are accepted in special cases. The boys outnumber the girls two to one. I.Q. ranges of the patients fall between the mild range of retardation to extremely gifted. The Center does not accept severely retarded or custodial children. All must have the potential for improvement. The population, however, is divided equally between short term (30 to 90 days), and long term (120 days to one year) patients.

This physical plant is non-hospital in appearance. The rural setting gives the feeling of a large, ranch-like structure. The entire facility is on one floor, and is just a little larger than a football field under roof. The agriculture program covers about eight acres, including a large greenhouse, a truck farm, and a fruit orchard.

The staff dresses in street clothes. Nurses, therapists, and social workers, may be seen in jeans and tee-shirts harvesting turnips along with the patients.

In-Hospital Course

The use of in-hospital time includes combinations of school work, therapy, and agriculture. The patients are automatically assigned to a staff psychiatrist to be seen individually at least one hour a week, and to a group therapist to be seen three times a week. More acute patients are seen more often, as indicated.

School is conducted from 9:00 A.M. to 3:00 P.M., five days a week, while the agriculture program is conducted from 9:00 A.M. to 5:00 P.M., seven days a week. The patients are divided into groups or teams, each group being headed

by a milieu therapist. This therapist accompanies his group to the various activities throughout the day. Every group attends the agriculture program every day as a group, and individual children are removed from the group and sent to agriculture for longer periods when indicated.

Method in Agriculture

The success of the "Aggi" program could be attributed to several reasons. It could be the setting itself, or it could be a combination of the setting and the person who runs it. "Dutch," as the children call him, is 6' 2", 280 pound therapist who cannot be manipulated. The children feel his love as well as his strength. When Dutch is present, no walls are necessary.

Agriculture is an open setting separated from the main building by two acres. There are no fences. When a child is sent to "Aggi" for the first time, Dutch sets limits for him. He is told what is expected of him. When he understands what therapists and his peers expect from him, ego boundaries are set. These are not the sort of ego boundaries that frighten a child, but rather the sort that bring pleasure to him. This helps him gain control, helps to put him in contact with reality, and enhances his ego by the creativity in the agricultural work. The children experience stimulation, projection, and creativity.

There are five major steps to the "Aggi" program.

1. Greenhouse
2. Vegetable gardening
3. Landscaping
4. Grove and service of grove
5. Plant rentals and groundskeeping.

The full detailed outline of these five steps is available upon request. The children are led through these steps at a level commensurate with their abilities. Almost without exception, the children choose soft, colorful plants. Cactus-like plants have never been chosen in the two years "Aggi" has been in operation.

Results

Psychotic children are able to start something, see it grow, take care of it, and in the end, have something for themselves. Dealing with living things right from the moment of birth is a marvelous experience. It helps them to see their own creativity; that they are not bad, and that dealing with plants brings beauty into their lives.

A., a 16-year old, came to Grant Center as a catatonic schizophrenic. He is now well on his way to a useful life. He came out of it through the "Aggi" program. Now, A. wants to be a gardener. He assumes responsibility for watering all of the plants inside the Center, carries on a coherent conversation, and talks about returning home in a few months. He has been in the Center for eight months.

B., a 12-year old, came to the Center one year ago. B. had withdrawn into a world of fantasy, and communication between the patient and her mother became almost impossible. B. spent a month preparing a plant for her mother for

her birthday. A great deal of emotional energy went into this plant, and thus, to the mother. There is a great improvement since B. began actively participating in the "Aggi" program.

C., a 15-year old, compulsive, explosive child, has received all of his controls through agriculture. He came to Grant Center after several years as an inpatient in a conventional closed setting. A good part of the years was spent in restraints. C. was just discharged. He will continue returning to the Center for outpatient therapy. His training in "Aggi" will enable him to seek gainful employment in a plant nursery or on a farm.

D., a 11-year old, also an explosive child, gained controls through the "Aggi" program. D. destroyed \$9.00 worth of plants in a fit of rage. He had to pay it all back, and he was restricted from attending "Aggi" until the \$9.00 had been repaid. The restriction motivated him to work harder at maintaining control since "Aggi" is his favorite place. He is currently attending "Aggi" for two hours a day. His incidences of explosive behavior have been reduced to almost zero, and he is preparing to enter a group living home.

No resistance has been found in the psychopathic personality to the agricultural program. These children respond very well in the setting, and acting out is at a minimum. Chronic run-aways do not run despite the totally open setting. The teen-age population seems to thrive on the "Aggi" program. More resistance was expected since the teen population at the Center had preferred the air conditioned inside to the heat and humidity of the athletic field. They never complain about going to "Aggi".

The anal child, such as E., seems to benefit greatly from "Aggi". E., a 15-year old, came in with the dual problem encopresis and withholding. The "Aggi" program provides a means of working through intrapsychic problems of the child. By showing him through all the stages of "Aggi", he is being shown how to deal with anger through adequate ways. He is dirtying his hands and his clothes and enjoying it.

The mentally retarded population with emotional disorders have been more difficult to treat. They do not have the insight into their problems as do their more intelligent peers. Through "Aggi" they achieve a beautiful end result to their efforts. It is good for their ego. For the child who is not really verbal, a plant is almost a companion. It responds to tenderness and love, and grows to a beautiful reward for his efforts. He learns to care for living things. He learns that if he does not care for his plant, it will wither and die. All living things require love and care.

The plant sale is almost like having a graduation. Everybody is able to help in the phase of creativity, and then go out and discover that this creativity has a great deal of value, not only in beauty, but in money. The most explosive, difficult children, stood outside a shopping center the day before Easter for eight hours. There were no run-aways, no outbursts, no one tried to steal the money, and everyone was happy. The children sold over 300 plants. The proceeds were used to enhance the "Aggi" program as well as for a "Burger King" party for the children.

Discussion

Agriculture is a unique modality in the treatment of an emotionally ill child. Since many conventional settings cannot provide an open setting for a greenhouse, a program of a lesser degree could be instituted using house plants. The processes of planting, nurturing, and harvesting, could be duplicated with any "Aggi" group in any setting, provided the structure and supervision were present. When a patient comes in for therapy, a process begins. Side by side, the child and his therapist reach toward the final goal—a healthy personality. At Grant Center, experience has shown that as the plants grow, the child's ego grows. Day by day, ego-boundaries develop, explosive behavior diminishes, and withdrawn patients begin to communicate. The greenhouse is a most exciting scene providing a new and refreshing approach to the psychiatric inpatient treatment of children and adolescents.

A STRUCTURED ACTIVITY TO FACILITATE ADOLESCENT GROUP PSYCHOTHERAPY

Billie F. Corder, Ed.D.
Child Psychiatry Training Program
Dorothea Dix Hospital
Raleigh, North Carolina

A recent survey of the adolescent population in a representative regional state mental health facility in North Carolina indicates that the majority of adolescents referred for group therapy within the hospital setting have limited verbal skills and many are functioning at a low normal to borderline level of intelligence. Typically they have had limited access to, or involvement with any type of psychotherapy prior to hospitalization and have histories of either acute psychotic reactions, various types of serious acting out, or anti-social behaviors which are perceived as dangerous or disturbing to the community. Many of these adolescents require much preparation and support for participation in any type of group interaction and process, have been consistently unable to function within community schools, and have few of the basic verbal skills and interpersonal experiences which would allow them to profit easily and readily from traditionally oriented group psychotherapy approaches (Naylor and Corder, 1975). The approach described in the present paper was developed to provide structured therapeutic group activities which would foster specific skills and behaviors appropriate for therapy groups which focus on fairly simple social adjustment issues. The specific behavioral skills were defined as improvement in ability to verbalize feelings and feeling states, along with capability for giving and responding to feedback about behavior from others.

PROCEDURE: *Patient Groups:* Adolescents within limited age ranges (12-15, 16-19) and levels of social experience are referred (usually by the staff of the special education school they attend) in groups of 6 to 8 for a "social-adjustment" group which meets one hour weekly. Participation is voluntary and preparation for the group consists of an individual meeting of each patient with the co-therapists where group goals are described briefly and a tentative "therapy contract" is made. The adolescent is asked to commit himself to at least one school semester of participations, abiding by rules developed within the group, and to working on any one problem area selected by the adolescent (usually something fairly simple, such as "I'd like to not have such a hot temper.") Each patient is given a copy of the booklet, "Introduce Yourself to Transactional Analysis" (McCormick and Campos, 1970) with instructions to read what they can understand of the material which will be discussed later in the group. The first session follows this general format: 1.) brief introductions, preferably by diads where arbitrarily paired patients introduce each other with a few simple facts and whatever additional information each desires to reveal. 2.) Group goals are briefly restated and after each patient names their own particular "goal" (the problem area selected earlier), some tentative basic rules for behavior are developed and voted on by the group (no hitting, leaving the room, interrupting before thoughts

have been expressed, all information is held confidential except when it concerns something which might endanger the patient or another person, no calling names etc.) 3.) "The Game" is introduced, and used to structure the entire first session, gradually increasing discussion time between individual "questions" and tasks until group interactions appears adequate without this structure. "The Game" is also used to introduce in a didactic form some of the simple didaephte about Transactional Analysis introduced in the booklet.

MATERIALS: *The Game:* "The Game" consists of 1.) a series of questions or tasks at 2 levels of intimacy and interaction skills to be used at various stages of the group process which are placed in a series of numbered envelopes.

Each player spins the arrow of a simple numbered plastic disc (available at school supply stores) in roulette wheel fashion, and answers the question or completes the task from the envelope matching his number from the spin. After each member has had a turn, the group designates someone to read the "learning card" (stacked in sequence in the middle of the floor) containing some question or information about T.A. concepts to be discussed by the group. The materials for "The Game" were developed by the author from clinical experience and from restructuring some selected exercises and examples (stating them in language and situations which were age and experience appropriate for this group) from *Born to Win* (James and Jongewald, 1971) and *Introduction to Transactional Analysis* (Abbey and Owston, 1973). Each of the items was then sorted into two levels of difficulty, using levels of verbal skills and degree of intimacy and disclosure required as sorting criteria, by two clinical psychologist "judges". Two examples of each of the two levels of tasks, and of the "Learning Cards" are as follows:

Level One: 1.) Tell what things about you are like your mother, and what things about you are like your father. Ask each person in the group to do the same thing. 2.) If you could only change one thing about yourself, what would you change? Why? Pick two other people in the group and ask them the same question. 3.) Does the way a person acts on the outside always show how they feel on the inside? Give an example using something about yourself. Ask one other person to do the same thing.

Level Two: 1.) Tell the person sitting on your right something they said or did that made you uncomfortable or feel bad. Ask them to do the same thing for you. 2.) Suppose a bunsen burner explodes in science class and the teacher is burned. You are all in the class. Tell what you think you would like to do, and how you think you would really act. Now go to the person opposite you and tell how you think he would act. Then let him say whether he thinks you are right or wrong and why.

Learning Cards: 1.) What does the book mean by Parent, Adult, and Child? 2.) How can you tell if somebody is acting on this parent, his adult or his child? 3.) What does feeling "O.K." and feeling "Not O.K." mean in the words we use in this group?

RESULTS:

In the initial three groups with which the materials have been used, the first three to four weekly sessions were largely structured by "The Game", with gradually lengthening discussion times between questions. By the second month, at least one-half of the session was structured by the therapists' directions, "Now that we know each other better, we'll spend half the time at the first of the session to give everyone a chance to let us know what is going on with them . . . what they have been doing and feeling. Then if you like, we'll spend the last half hour with "The Game"." Gradually the groups lost interest in the materials and only a few of the Level Two items were necessary or utilized. After group skills and expectancies for behavior were structured by the materials, continued use appeared to inhibit intimacy and spontaneity. Role playing was introduced fairly early in the sessions when group members began to have difficulty in expressing themselves. They were asked to "act out" many of the situations they described in the free discussion periods, and later some of the Level Two role playing tasks were assigned to the group after formal use of the materials was discontinued. Patients were asked to describe some conflict situation, assign roles to other members, and discuss their reactions and feelings to the enacted scene.

The materials of "The Game" were viewed as a preparation for the use of group therapy techniques with these adolescents, and for facilitating rapid interaction and exchange in fairly short-term treatment groups. The therapists and observers of the group (closed circuit video equipment is sporadically used for staff observation of groups) agreed that the structure provided by the use of the materials helped to quickly set expectations for listening, feedback, and sharing of verbalized feelings with these adolescent patients, as well as fairly painlessly introducing Transactional Analysis concepts in small didactic doses.

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THE ABUSED CHILD PROTECTION COMMITTEE

John F. Tedesco, Ph.D
University of Virginia
Charlottesville, Virginia

J. D. Ball
Blue Ridge Community Mental
Health Center
Charlottesville, Virginia

Child advocates throughout the nation, particularly in rural settings, can easily find themselves victimized by their own attempt to help curb child abuse. Failure to appreciate characteristics of rural communities, role definitional problems, and legal entanglements can destine a rural child protection agency to complete frustration. The child protection committee reported here was established in a rural Virginia County. Since this committee exemplifies the naivete, enthusiasm and concern of child advocates elsewhere, it can serve as a learning experience. The paper attempts to illustrate some of the important mistakes in the development of unsuccessful child protection committees. The following steps to frustration are offered in the hopes that they can be avoided by others.

The Path to Frustration

An excellent way to make an early error is to completely disregard the conflicting goals of treatment oriented child-advocate committee members and punitively written child abuse legislation. Most current laws concerned with child abuse attempt to coerce members of helping professions and citizens to report suspected cases of child abuse. The person reporting the abuse is typically free from civil liability. The legislation negates physician-patient and husband-wife communication privileges.

Typically, workers in child protective services will be faced with simultaneously wanting to help parents and needing to remove children from desperate situations. These sometimes separate goals can result in a "we" against "them" picture on the part of child abusing parents, and often a "cops and robbers game" ensues with almost no child abusing parent confessing guilt or voluntarily seeking treatment.

In the case of the present committee, the professionals were highly motivated by a state child abuse meeting. Personnel on the committee included the probation officer, the school psychologist, the visiting teacher, the sheriff, a public health nurse, a social worker and a part time clinical psychologist from a community mental health center. In an attempt to avoid negative associations, the committee termed itself a child protection committee. Next, committee members decided that their first tasks were to educate the public about their own existence and about child abuse in general and to create a confidential file. At no time during these initial meetings did the committee consciously confront the contradiction between their own goal of helping parents and children, and the legislative emphasis on helping the children, possibly at the parents' expense. Despite efforts to present themselves to the public as a non-punitive helping agency, the committee had the distinct impression that the community already perceived its role as punitive.

A second step to a committee's ineffectiveness and discouragement is to omit important members such as physicians and lawyers. The physician is needed to define and document physical injury, and the lawyer is invaluable for determining appropriate legal grounds for child abuse. In our own case these individuals were difficult to locate, let alone have serve on a committee. Moreover, a physician who agreed to serve on such a committee might well risk a reputation as a community "traitor" and a dwindling business. Faced with these obstacles and its own naivete, the present committee chose to move forward without these essential members, a move the committee later regretted.

A third contributor to a committee's impotence is keeping the responsibility for case investigation totally diffuse. The agency designated with this responsibility may be apathetic, afraid or simply overworked. In the present case the designated agency was not responsive, for various reasons, to child abuse issues. The committee agreed to share case investigation and maintain a non-punitive approach. Our non-punitive investigating team was left on the porch of many homes, unable to see behind closed doors. Moreover, there was disagreement between members' philosophies. What was neglect to the social worker was life skills training to the public health nurse.

Finally, a rural child protection committee's inefficiency depends upon its willingness to disregard rural phenomena. An effective way to be ineffective in a rural setting is to pretend you are operating in an urban setting. Because many of the health services in rural communities are provided by "outside professionals" there is initial distrust of these agencies. A child protective committee comprised of representatives from these groups has public resistance to overcome. Additionally, many of these health workers are part-time employees, available to the community only infrequently. The inclusion of part-time workers on a child protection committee severely limits its response time and its community involvement. Committee members in the present case did well to meet monthly while an effective group should be prepared to convene within twenty-four hours notice.

Aside from trust and availability, our capacity for identifying abuse or neglect was hampered by a tremendous social cohesion characteristic of these areas. Especially in rural areas, community leaders and middle class citizens rarely identify child abuse cases within their own social spheres, but are quicker to reveal suspected incidences among the not so respected, not so powerful lower class. Additionally, while urban committee's typically operate out of a hospital or are closely affiliated with one, rural committees frequently have no hospital available. This committee failed to make an efficient liason with nearby hospitals and neglected an important resource.

The committee's last task was to examine more effective rural child abuse committees. This examination, as well as our own analysis, resulted in the following suggestions. The successful committee: (1) operates from a hospital when possible; (2) is composed of full time people; (3) contains essential committee members at its inception; (4) can meet within 24 hours of a child abuse report; (5) confronts and resolves its role conflicts; (6) locates the community agency responsible for investigation; and (7) recognizes rural cohesion.

Whether or not the problems discussed contributed to our self abuse is unclear. However, the committee ceased functioning after two years with no reports of child abuse from typical sources. Reports were from members of the committee themselves. Typically a name would be mentioned and all of the committee members would be familiar with the case and repeat as a chorus "Oh, yeah." Ensuing conversations resembled gossip and the case would then be dropped.

Legislative Implications

Committee members felt that their untenable position was enhanced by the fact that the law destines child protective workers to be perceived as punitive rather than helpful. As an example of this, the new Virginia law provides for a twenty-four hours a day, seven days a week hotline. Rather than being used for parents in crisis, however, the intent is for use in registering complaints. The idea of being perceived as punitive is particularly important in a small rural community in which people are well acquainted with one another. Parents perceive reporting themselves as asking to be sent to jail and/or having their children taken away. The law has increasingly attempted to put parental responsibility in the hands of others. It is true that many child abusers are at least in some ways not appropriate parents, and it is true that many children are in desperate situations. The question of whether or not others should be given this responsibility under a punitive system remains to be seen.

One possible change in the direction of the law might be to put parental responsibility back into the hands of the parents. Suspected child abusers could perhaps be prosecuted only upon failure to report themselves as such. If child abuse is to be perceived as some type of mental illness, a larger focus should be on treatment rather than retribution. This change could include the establishment of a clear step by step system for dealing with the children. In the less severe cases, the child could remain in the home and the parent could take advantage of a helpful hotline or community volunteers who could assist in times of crisis. Other forms of community treatment such as parents anonymous, parent education groups, parent training in the schools, and traditional types of intervention such as psychotherapy could also be offered while the child remained in the home. A next step might include live-in community volunteers or relatives who could assist in child care tasks. In still more serious cases intervention might include part time removal from the home, with the ultimate goal of returning the child as soon as possible. The last step would be eventual removal, if no progress could be obtained by earlier procedures. If interventions work, it would be rare that the latter case would be needed. If interventions do not work, perhaps the old law is better.

MINIMAL CEREBRAL DYSFUNCTION

Henry Berger, M.D.
Philadelphia Child Guidance Clinic
Philadelphia, Pennsylvania

The diagnosis of minimal cerebral dysfunction usually includes certain therapeutic implications. While it is true that such a diagnosis means that the child may need individualized attention, in the form of medication to control hyperactive behavior, special education for learning problems and possibly individual therapy to help the child cope with his problems, an additional dimension to therapy needs to be considered. This involves a consideration of the impact of the child's difficulties upon the family and the effect of dysfunctional family patterns of behavior upon the child. Certainly any major disability will have certain repercussions within the family system and the individual is likely to be affected by the way in which his disability is handled by those in his immediate environment. Children with minimal cerebral dysfunction may be particularly vulnerable to environmental stress because of the peculiar nature of this problem.

The characteristics of this problem which may make the child vulnerable to dysfunctional family patterns have been previously discussed. First, there is the child's need for more parental guidance, limit setting and general attention to help the child handle frustrations and anxieties.¹ Secondly, these children are more prone towards developing a negative self image and poor peer relations than children without this problem.² It is largely the task of the family to help the child in each of these areas and consequently inappropriate family behavior will have a greater impact upon these children than upon the average child. Evidence suggestive of this conclusion is the fact that followup studies of children with minimal cerebral dysfunction have shown increased numbers of emotionally ill adolescents and retrospective studies of adult psychiatric inpatients show a large number having been diagnosed as MCD as children.^{3,4} While such difficulties may in fact be related to a primary effect of the disorder, it is not unlikely that it is also a result of failure of the environment to meet the increased demands of these children.

Experience with five families of MCD children suggests that certain dysfunctional patterns do, in fact, seem to develop in such families. This paper will discuss some of the characteristics seen in these families, attempt to characterize them as part of more generally observed phenomena of dysfunctional family patterns and finally describe in some detail the diagnoses and treatment of two families. While this paper focuses upon the familial patterns and therapeutic intervention within the family it should be kept in mind that other forms of help were also given where necessary, such as medication, special schooling, and individual attention.

Patterns of Dysfunctional Family Behavior

One of the particularly common patterns observed among this group has been the tendency of the other members of the family to view the child as bad,

disobedient or malicious. While one can understand such misinterpretation of the behavior because of his tendency toward hyperactivity, tantrums, etc., it becomes more difficult to understand when it develops to the degree seen in some of the families. Such an attitude towards one child was present not only in the immediate family, but involved members of the extended family as well to the point that the child was not welcome at particular family gatherings because of his "vicious" behavior. One girl was blamed for potentially and purposefully breaking up her mother's marriage and a third family asked to have their son removed from the home. Such patterns when seen in other families is easily recognized as "scapegoating", i.e., the selection by the family of one of its members as the problem of the family, and the source of all of its difficulties. In evaluating families with a child with MCD, the fact that the child has a problem should be kept in mind, and a certain amount of familial frustration and anger are expected. In the families seen, however, the willingness to assign motivation to the young child's behavior, as well as the extent of overt hostility towards the child, suggested that more was going on. For, when these families were examined more closely, it was learned that similar behavior by other children within the family was either ignored or reacted to much less violently. Also, it was seen that these families were unable to discuss the positive accomplishments of the affected child. Finally, very little in the way of positive attention was given towards the affected child. The need for maintaining such a dysfunctional pattern, as in other scapegoating families, appeared to result from a desire on the part of all members of the family to avoid certain potentially explosive or painful conflicts within the parental subsystem.

Children with MCD seem particularly vulnerable to being selected as scapegoats. First, their atypical behavior, slow development and increased need for parenting make them obvious targets. Once selected as the scapegoat, the effect upon their self image can be significant. Compared with children without MCD, they have fewer areas of competency in which they can develop positive self esteem and consequently are more vulnerable to the destructive effects of being chosen as the scapegoat. Clearly, when such a pattern exists it is necessary to intervene in such a way that not only is the child removed from the position of the scapegoat, but the families' need for a scapegoat is removed.

A second pattern also seen among these families is the tendency of one parent to become overinvolved or overprotective of the index patient. Again, as in the scapegoated child, an effort must be made to differentiate appropriate from inappropriate behavior. In this case, it is certainly natural to expect the parents to be particularly concerned with the MCD child because the nature of his problem requires increased parental attention. Factors which seem to suggest a dysfunctional pattern include the overprotective attitude of one parent as compared with the exclusion of the other. Also, the extent that the child has become the center of the world for one parent may suggest a dysfunctional pattern. Finally, the resistance encountered from the overinvolved parent to efforts toward disengaging the child can give a clue as to the presence of a dysfunctional pattern. A striking example of this problem occurred in one family where a seven year old boy was

the index patient. As a result of his mother's wishes, little effort was made in disciplining the boy. Nothing was even done when the boy threw a brick at the windshield of the family car during a mild tantrum. The excuse given was that he hadn't broken the window.

Such an overprotective attitude may be the result of the unmet object needs of one parent who is closely involved with the child. This may be the result of their own frustration of dependency needs, or an unsatisfactory marriage in which one or both parents is not gratified. The MCD child may be chosen as the source of attention because of his apparent and real need for increased parenting, as well as his difficulty in finding satisfying peer relations. The result of such a pattern is to leave the child more dependent upon his parent than need be, and possibly as in the case cited, a gradually developing sense of helplessness in handling his impulsive wishes. When such acts as described above go unchecked, the message to the child can only be that even his parents are incapable of restraining him. Finally, an overprotective attitude on the part of the mother can interfere in the child's ability to join with peers or to enter and participate actively in school activities. These, of course, are areas of difficulty for the MCD child even under ideal circumstances. The therapeutic effort should be made to disengage the child and to help the parents find gratification in each other if possible.

A third pattern seen to exist among the families which were studied is one which seems to be related more than the others to the special characteristics of the problem of minimal cerebral dysfunction. This pattern is perhaps best described as the "organic-emotional" split. It seemed as if some of the families became preoccupied with either the organic or the emotional aspect of their child's problem, as if the two could, in fact, be easily separated. For some families, the idea that their child suffered from "brain damage" was so unacceptable that it was extremely difficult for them to accept his real limitations. Instead they preferred to look for emotional factors which might explain the impaired speech, hyperactivity, or learning difficulties. In contrast, some families were so resistant to the idea that emotional factors may have contributed to the child's problems, that they preferred to see all of the child's problems as caused by his "brain damage". In the families seen, those which viewed the problem as emotional either tended to scapegoat the child or to overprotect him. One family which saw the problem as organic maintained an overprotective attitude. One can hypothesize that, while there are many factors which may cause a family to artificially characterize the MCD child's problem as emotional or organic and to choose one or the other as the main problem, one contributing factor seems to be the need to incorporate the child into a dysfunctional family pattern. As a result, the child's problems are viewed in such a way as to fit the pattern of the family rather than the real situation. The distorted view of the child's problem as well as the distorted attitude towards the child seemed to derive from the special unmet needs of the family members. Consequently, it is necessary to consider these needs, and help the family members meet them appropriately before they can be helped to view their child's problem realistically.

The following are descriptions of two cases. The first is one in which the index patient was overprotected by his mother, the second, in which he was scapegoated by the family:

Case I

A., a six year old boy, was brought to the clinic for evaluation of his articulation difficulty. Previous testing had shown central perceptual disorder, and he had received three years of speech therapy, with moderate success. At the time of evaluation his parents' major complaint was that he was shy, withdrawn, and extremely sensitive to criticism. His school had suggested that he be held back in kindergarten for a second year.

A.'s shyness and fears prevented him from establishing peer relations, compounded his speech problem, and kept him in an extremely dependent relationship with his mother. Mrs. A. encouraged this relationship in many ways. When not at school A. rarely left her sight, had no responsibilities at home and was denied few wishes. During the initial interview it was noted that Mrs. A. tended to interpret her son's speech rather than allow direct communication between the therapist and A.

Further evaluation revealed that Mrs. A. had been chronically depressed for some time, accused her husband of extramarital relations, and was concerned that he was becoming "alcoholic". Mr. A. admitted to previous affairs which he had stopped. His constant anxiety about failure caused him to drink and seek extra marital relations.

Therapy aimed not only at helping the family to encourage a more independent attitude on the part of A., but also at changing the dysfunctional relationship which had developed between Mr. and Mrs. A. The result was that A.'s shyness and withdrawn behavior changed significantly, Mrs. A's depression was alleviated and Mr. A's drinking problem was controlled.

Case II

B. was referred to the clinic because of his destructive, undisciplined behavior. B., who had always been an hyperactive child, had been placed on methylphenidate at age seven in a successful effort to control his hyperactivity. He had also been in a special education class at school until the school policy was to have all children "mainstreamed" back to the regular classes. At the time of referral the school complained that B. was hyperactive and not attempting to do his school work.

During the initial interview Mrs. B. stated she wanted B. out of her home, that she could no longer "stand him". She said these things in the presence of her son in spite of the therapist's attempts to avoid what was felt would be destructive hostility. Mr. B., who was quiet and more controlled than his wife, nevertheless supported her description of B. The fact that throughout the interview B. was the best behaved of their children was explained by the parents as his effort to "win over" the therapist. It was also learned that even though she could not stand B's behavior at home and he had been a problem at school,

Mrs. B. gave him a less than sufficient dose of medication to control his hyperactivity, stating that she did not want him to be an addict. This and other factors pointed out the apparent need to keep B. in a scapegoated position.

As therapy progressed it became clear that Mrs. B., who in fact had seen herself as the "black sheep" of her family, felt herself in too insecure a position within the marriage to confront her husband openly in disagreement. Therapy aimed, therefore, at not only removing B. from his scapegoated position but also at reducing the need for a family scapegoat by allowing open, direct confrontation between husband and wife.

Conclusion

The fact that a child is diagnosed as having minimal cerebral dysfunction should not cause the therapist to ignore the potentially destructive environmental influences. On the contrary, such children are more vulnerable to negative influences, and probably more susceptible to being selected by the family to fill a special inappropriate role. It is hoped that such an approach can help to prevent many of the problems which these children face as they grow into adolescence and adulthood.

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THE DEVELOPMENT OF A TUTORIAL PROGRAM WITHIN A CHILD PSYCHIATRY CLINIC: ITS ESTABLISHMENT, MANAGEMENT, AND COMMON PITFALLS

Carla L. Shill, M.Ed.

Child Psychiatry Outpatient Unit
Dorothea Dix Hospital, Raleigh, North Carolina

Establishment

An important aspect of the total psychiatric and psychological evaluation of a child is communicating the results and recommendations, especially educational recommendations, to the child's school teacher. At the Dorothea Dix Child Psychiatry Outpatient Clinic, the position of psycho-educational consultant was created several years ago for just such a purpose—to give feedback on the results of psychological testing and to formulate educational plans which might better meet the child's needs. Occasionally, however, the child's educational deficits are so severe that the regular classroom teacher has difficulty individualizing her curriculum to meet the child where he is currently functioning, academically and behaviorally.

The psycho-educational consultants at the Dix Child Psychiatry Clinic decided to use the liaison they already had with the psychology department of North Carolina State University to set up a tutorial program using State students as tutors. The professors were quite willing to give students credit in their courses for participating in the tutorial program.

The next step in establishing the program was to approach the elementary school superintendents of Raleigh City and Wake County Schools to secure their permission to allow tutors to work with the children during school hours and using some school equipment. We found the administration generally enthusiastic about our plans, but anxious that the tutors be consistent in their work. These superintendents had had prior experience with other tutorial programs which had been poorly managed and in which tutors dropped out of the program leaving the child "in the lurch." We felt that since the number of children to be tutored was small (about 25), we could offer adequate supervision to insure consistency. Also, since they received credit towards their final grades, it was more likely that tutors would be responsible in the program. When we gave these assurances, the elementary supervisors for Raleigh and Wake County Schools readily gave their permission for the tutorial project.

The next phase of establishing the program involved the selection of children to be tutored. We used two sources to form our population one was the Dix Child Psychiatry Outpatient Clinic which tends to serve middle-class families, and the Wake Memorial Hospital Behavior Clinic which serves mostly lower-income families. The Behavior Clinic meets once each week and is operated by staff members and trainees from the Dix Clinic. Two criteria were used to select children for the program; (1) there existed a deficit in reading ability at least

1 or 2 years below present grade placement, and (2) the child's needs were not already being served by the school system.

Management and Supervision

Once the tutorial program was established, we arranged with the educational psychology professors at NCSU to meet with their students at the beginning of each semester. The psycho-educational consultant described the children selected to be tutored to the classes and allowed the students to select children with whom they were interested in working. The tutors tended to base their selection on the nature and severity of the child's behavior and learning problems, and the distance of the school from the tutor's home. Most tutors seemed more interested in children with learning problems with little or no behavior problems. However, those who chose to work with behaviorally disturbed children found them to be quite manageable in the one to one situation and capable of a good working relationship.

The tutors agreed to meet with the child at least twice a week for 8 weeks or longer. We recommended that the tutors obtain copies of *Systematic Reading Instruction* by Gerald G. Duffy and George B. Sherman (Harper and Row, publishers). This book lists reading skills in a sequential manner and gives pre- and post-tests to determine mastery of each skill.

Each tutor—student pair was assigned to one of four psycho-educational consultants for purposes of supervision and follow-up. Each supervisor was responsible for taking each of his tutors out to the schools for a planning meeting. At this initial meeting between tutor and regular class teacher, a time and place for the tutor to meet with the child was established. More information was obtained about the child's specific weaknesses, and what materials had been used to work with him. There has been a great deal of variation in how helpful teachers were in specifically delineating where the children were in their reading skills and what materials seemed most appropriate.

After the tutors had met with their children at least two weeks, the supervisors began monthly meetings of the tutors in their groups. The purpose of the group meetings was to provide consultation regarding various aspects of the tutorial experience—the relationship between tutor and student, the relationship between tutor and teacher, the various approaches to teaching reading skills, plus finding effective reinforcers to aid attention and learning. Another benefit of the group meetings has been that tutors could gain insight from each other's work and thus widen their experience. Since the tutors usually had had no prior experience in teaching reading skills or working with elementary aged children, close contact was absolutely necessary to insure high-quality instruction.

Finally, at the end of the semester, each tutor was made responsible for filling out a one-page "Summary Sheet" on the student he tutored. Specific data here is sought on the behavioral and academic functioning of the child at the beginning and ending of the semester, kinds of reinforcers used and their effectiveness, and educational recommendations for the next person working with the child.

Common Pitfalls:

When untrained volunteers are assigned to work with problem children, certain difficulties may arise. The problems we have observed in our program are grouped into two main categories: problems between the tutor and student, and problems between the tutor and teacher.

In the first category, some common pitfalls are that the tutor regards himself as a "friend," rather than an instructor, tends to see too few limits, and takes the child off school grounds for trips. Tutors who are overly lenient often see themselves as a "rescuer" of the child from either a poor home situation or an unfavorable school situation. In one such case, the tutor spent increasing amounts of time with the child, a pre-schooler, and she became threatening to the mother. Firm rules must be established by the supervisor that the child is to be worked with *only* on school grounds and during school hours. If problems still persist, the tutor must be taken off the case. Tutors are encouraged to engage in pleasurable activities with the child such as card games, basketball, etc., but only as a reward for completing academic assignments, and only on school grounds.

Difficulties can also arise in the situation where the tutor affectively distances himself from the student to the point that he is ineffective. Examples of such problems are the tutors who do not establish a regular time to see the child and stick with it, those who do not accurately assess a child's reading or math ability and consequently do not teach on the child's level or use appropriate educational materials, and those who do not reward a child's efforts frequently enough or effectively enough. In some cases of more severely disturbed children, tutors are sometimes "turned off" by a child's bizarre behavior and find it difficult to structure the session enough and to firmly limit the child's inappropriate behavior. Again, the supervisor must help the tutor structure his sessions academically and behaviorally so that they are more rewarding to both tutor and student.

We have also seen several kinds of problems in the other category—the relationship between the tutor and classroom teacher. At times, teachers have viewed the tutor as a "student teacher" and will attempt to have him help with other children in the class rather than the one child he was assigned. In another case, the teacher used the tutor as a reward for the child to which he was assigned, and would not allow him his regularly scheduled time with the tutor if the child had been misbehaving. Other difficulties arise when a teacher overstructures the tutor's time, or does not give enough help and guidance to the tutor. In the first case, some teachers attempt to have the tutor help the child complete class assignments with which the teacher has been unsuccessful. In the second case, teachers are unfamiliar themselves with the child's academic difficulties and are not good resources for the tutor in terms of appropriate teaching techniques or materials.

Problems in the teacher—tutor relationship are often due to a teacher's feelings of inadequacy or guilt concerning the problem child, jealousy of the tutor being able to work individually with the child and their realizing more

progress than the teacher has made. Consultation between the tutorial supervisor and the teacher may reassure the teacher of her central role in the child's overall education and help her function more appropriately as a resource person for the tutor.

Benefits:

Obviously, there is much hard work needed on everyone's part to make a tutorial program work. There are some outstanding benefits for the child, the teacher, and the tutor if the supervisor has done a good job of preparation and guidance. The biggest benefit, of course, is when the child's ability to read increases, and thus his self-concept improves. Sometimes significant gains in reading skills are made over a period of one or two semesters due to individualized instruction and the one to one relationship between the tutor and child. In one particular case this year, not only did the tutor increase the child's reading ability, but also loaned the teacher some worksheets she had prepared which the teacher then used with the rest of the class. This, in turn, helped the child re-integrate with his classmates and gave him additional success experiences which he rarely had before tutoring began.

Another significant benefit of tutoring is that the regular classroom teacher becomes more sensitized to the child's special needs and may individualize her curriculum to a greater extent. In addition, to this, a kind of "Hawthorne Effect" often develops in which the teacher sees the child as more capable when he begins to improve. This changed attitude on the part of the teacher may alter the quality and quantity of interactions with the child and account for academic progress in and of itself. This same Hawthorne Effect may be responsible for much of the child's progress within the tutorial sessions, rather than the actual instruction he is receiving.

Aside from the child and teacher, benefits also accrue to the tutor, who gains practical experience in teaching and in relating to a "problem" child. Some tutors are in graduate school to gain teacher certification; the tutorial experience helps prepare them to handle similar cases when they begin full-time teaching. Others benefit simply from participating in a close relationship with a child who is experiencing behavior and learning problems. They learn that these children are responsive to a positive relationship and capable of growth despite certain handicaps. In addition to this practical experience in working with a child, the tutor is often able to enhance the teacher's ability to work with that child by sharing the techniques and materials that have been successful.

Finally, the tutorial program as it has developed at the Dix Child Psychiatry Clinic, has been quite beneficial to the clinic itself. Parents who bring their children for weekly therapy because of school-related problems see the clinic as capable of rendering immediate and concrete assistance in the form of tutoring, in addition to long-term parental counseling and psychotherapy for the child. This often brings a sense of relief and trust that their child can get better.

Conclusion:

As our tutorial program develops, research will become a more important aspect in the whole project. Two important questions to answer are: how effective is tutoring in increasing reading skills? Is the individualized instruction responsible for this progress, or is it the one-to-one relationship? Now that we have adopted *Systematic Reading Instruction* as the primary "text" for tutors to use in their work, it is possible to have control and experimental groups to begin gathering data.

For any school consultant who may be contemplating developing a tutorial program for their clients, we would suggest that although tutors can often widen the service the consultant is able to offer the classroom teacher and child, the tutor is not a "short-cut" for the consultant. Rather, the successful tutorial program is founded on good liaison work with both school authorities and tutors and continuing supervision and consultation with tutors and teachers.

DELIVERY OF MENTAL HEALTH SERVICES TO RURAL CHILDREN: DESCRIPTION OF A MENTAL HEALTH PROGRAM IN RURAL NORTH CAROLINA

Jerry A. Coffey, Ph.D.
Smoky Mountain Mental Health Center
Cullowhee, North Carolina

The Smoky Mountain Mental Health Center serves the seven westernmost counties of North Carolina. This includes nearly all the area west of Asheville, North Carolina, and covers over 3,000 square miles. The population of the area is almost 115,000 with about 40,000 people living in the easternmost county. This means there are less than 75,000 people living in six of the counties and some counties have less than 5,000 people. Even though the Center has three full time facilities, the driving distance to these facilities would require at least a half a day out of school for a child. As a result, the Smoky Mountain Mental Health Center has chosen to provide its service to children at their schools on a regular basis. One child or youth psychologist has been employed for each 1500 students and is at each school on at least a once a week basis. The schools are conceptualized as "outreach" or "satellite" centers. The psychologists are not seen as traditional school psychometrists. In fact the model used dictates that very little testing be done.

One "hi-cube" van is assigned at each Center, equipped with carpeting, paneling, desk, and other office equipment. This van is used at schools which do not have adequate space for seeing children or meeting with parents and teachers.

The obvious advantage to this system is the saving of time for children and their parents with little if any loss of time to the psychologists. However, there are numerous other advantages.

1. The presence of psychologists at the schools makes referral by teachers much easier. There are no complicated forms to fill out. The teacher merely notifies the psychologist verbally. Because of this, it is suspected that referrals are made much earlier in the development of a child's problem.

2. Follow through is much easier. It requires only a few minutes to stop by the teacher's classroom as opposed to the complications of setting up a more formal meeting.

3. Children are less apprehensive about seeing a psychologist on the child's "own turf". Because the psychologist is regularly at the school, children already have an informal relationship with him and establishing rapport is easily accomplished.

4. The stigma of going to a mental health center is eliminated. While this is rarely a problem for young children, it is for their parents and for adolescents. The school is seen by most parents as being "safer". Often it is the place where the parents themselves went to school.

5. Because of the easy availability of the psychologists, several teachers have referred themselves for their own personal problems. The secondary gain for children whose teachers receive assistance for a personal problem is significant.

6. The teachers soon learn that psychologists are also skilled in dealing with academic learning problems as well as personal adjustment and behavior problems. The psychologists conduct workshops in all these areas at the school.

Rational Child Management

The approach used in the Child Program of the Smoky Mountain Mental Health Center is Rational Child Management (RCM). This is a reality-based approach which views most problems, whether in the academic or personal adjustment area, as motivational in nature. Various techniques are used including the achievement card, counting, contingency management, time-out, desensitization, and relaxation training. The psychologist serves primarily as a consultant in this program, training parents and teachers to carry out the management plan.

While RCM utilizes management techniques, it also includes a fairly well defined set of principles regarding the direction in which change *should* occur. For example, in the particular mountain culture in which RCM was started, responsibility and respect for work is adaptive and reasonable and is encouraged.

Rational Self Management

The approach utilized in the Youth Program is Rational Self Management (RSM). It is quite similar to RCM, in that it views most problems as motivational in nature. It also utilizes similar behavioral techniques such as counting, desensitization, and relaxation training. The major difference is that the adolescent himself is the agent of change rather than primarily his parents or teachers.

The Summer Program

A residential summer program will be started in the summer of 1975 for children aged 8-11 who are experiencing a variety of academic and/or personal adjustment problems. The program utilizes the RCM approach and is modeled in part from the Englishton Park Academic Remediation and Training Center. Each session is highly structured and focuses on: (1) individual skills including academics; (2) cooperative skills; and (3) competitive skills. Again, the program uses primarily behavioral management techniques, with each child having a highly individualized contingency management plan. Academic activities are closely associated or concurrent with play or typical camp activities such as swimming, crafts, and overnight camping. The program is set in the out-of-doors and takes advantage of the excellent natural resources in the area. Before, during, and after the summer experience, parents and teachers are trained to maintain the changes which occur in the children.

Staff

All staff members have at least a master's degree in psychology and at least two years experience (or equivalent) in working with children. In addition to the regular staff, three master's level interns and several master's level practicum students in psychology are receiving training in the program.

Financial Support

Funding is received from regular state mental health funds, NIMH staffing grant money, and from parents. In addition the school systems make significant contributions for staff salaries which indicate the local support the Program is receiving.

NOTICE TO CONTRIBUTORS

Manuscripts and editorial comments submitted for publication should be mailed to:

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Manuscripts should be submitted in triplicate, double spaced, and total no more than 15 typewritten pages. The format of headings, tables, figures, citations, references, and other details should follow the style described in the *Publication Manual of the American Psychological Association*, available from the Association at 1200 Seventeenth Street, N.W., Washington, D. C. 20036. Tabular material, drawings and charts must be limited, due to publication costs, and should be submitted on separate sheets.

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Guest Editor's Preface

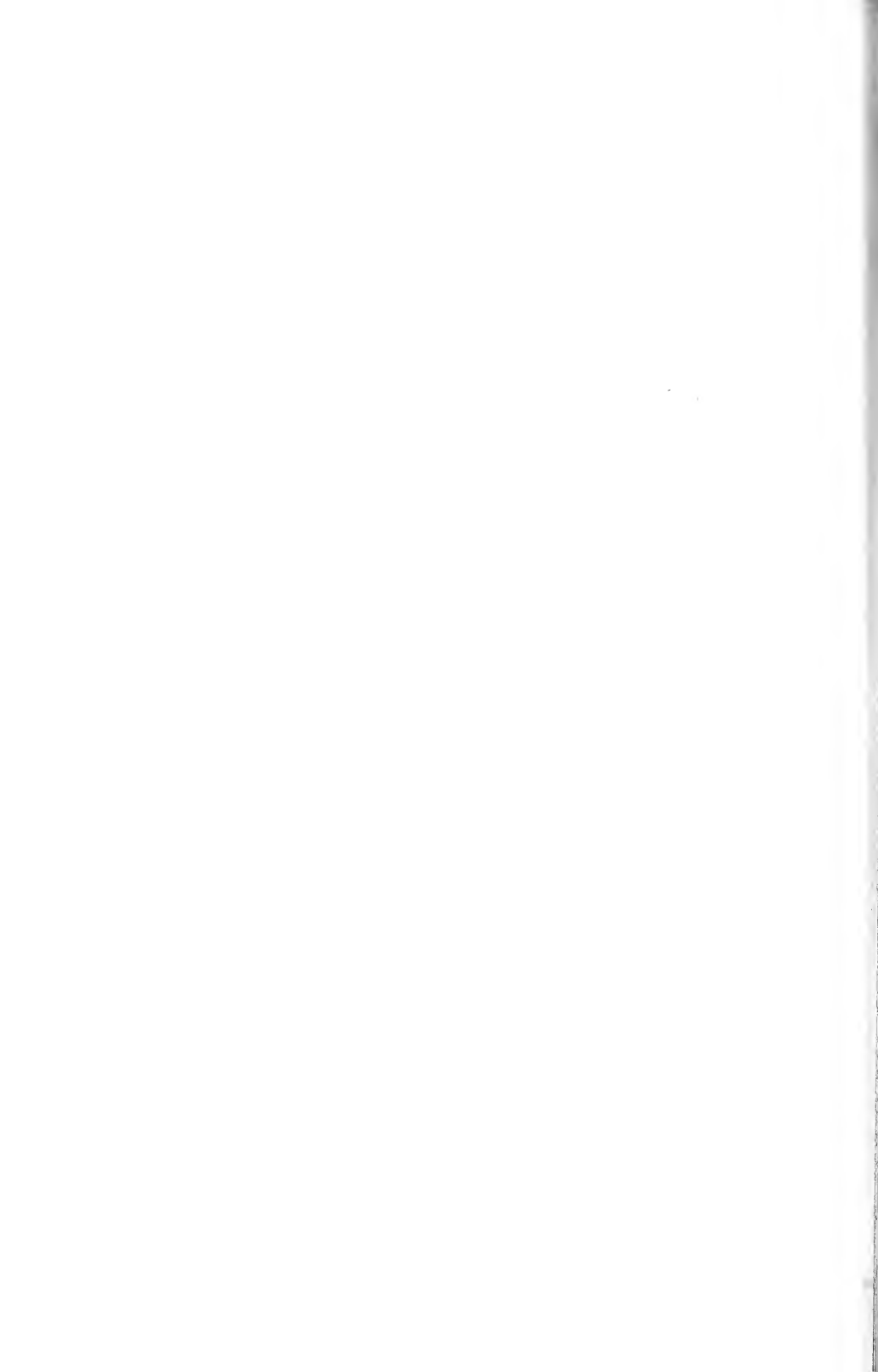
Our modern conceptions of neural, behavioral, and psychological development dictate intervention at the very earliest stages for those who are definitely "at risk" or are already impaired. This fundamental change in our orientation to mental health services stems in part from basic research with animals. Although there is perhaps an exaggerated fatalism in Alexander Pope's remark "just as the twig is bent, the tree's inclined," the scientific evidence indicates there is certainly *some* truth in this old adage. Embryological and other experiments make it clear that the process of development involves a progressive narrowing of the range of potentialities and, as development proceeds, malleability necessarily diminishes. There would appear to be something akin to "critical periods" at all levels of function: the anatomical, physiological, behavioral, and psychological. Though some functions may remain relatively flexible even in adulthood (in the sense of being highly responsive to, and influenced by, environmental circumstances), most functions show decreased "plasticity" with age. The corollary for intervention is obvious and thus it is that mental health programs for infants have been spawned.

In the present issue of the Journal, four rather different intervention programs for infants are described: three at Western Carolina Center in Morganton and one at the Frank Porter Graham Child Development Center in Chapel Hill. Although space limitations precluded the description of still other programs for infants in North Carolina, the present programs do seem to fairly represent the various approaches to the problem.

In addition to obvious humanitarian considerations, there is a heavy intellectual investment in these programs for infants. Not only are the outcomes of different treatment regimes being evaluated for their remedial value, some of our most fundamental notions and assumptions about human development are also being explicitly tested for the first time. To enable us to better appreciate how we arrived at this almost revolutionary stage of human service and developmental research, the first two articles in the issue describe the historical roots of our changing perspectives of infancy and document the case for very early intervention.

I wish to acknowledge the editorial assistance of Mary Catharine Vick in preparing this issue for publication.

Gilbert Gottlieb
Research Section
N. C. Division of Mental
Health Services
Raleigh, North Carolina



Mental Health Programs for Infants in North Carolina

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EDITORIAL FOREWARD

MENTAL HEALTH PROGRAMS FOR INFANTS IN NORTH CAROLINA

We wish to thank Dr. Gilbert Gottlieb who so graciously agreed to serve as guest editor for this special issue of the JOURNAL. Indeed, it was Dr. Gottlieb's initiative and enthusiasm that led us to undertake publication of an issue of the JOURNAL devoted entirely to this enormously intriguing and promising area of inquiry.

The Editors

Special Issue

**MENTAL HEALTH PROGRAMS
FOR INFANTS IN NORTH CAROLINA**

Gilbert Gottlieb, *Guest Editor*



CHANGING PERSPECTIVES OF INFANCY: PHILOSOPHICAL, PSYCHOLOGICAL, AND BIOLOGICAL VIEWS OF BEHAVIOR DEVELOPMENT

**Ronald W. Oppenheim
Research Section
N.C. Division of Mental Health Services
Raleigh, North Carolina**

" . . . the infant comes by his mind in the same way he comes by his body, namely, through the mechanisms of development . . . It cannot, therefore, be doubted that the general physiology of mental development will find its deeper roots in the same scientific soil which is now being intensively cultivated in laboratories of experimental embryology"

Arnold Gesell, 1954, pp. 335, 337

In view of the current intense scientific interest in the early behavioral and neural development of animals and man, and considering the related social problems of establishing scientific guidelines and support for critical political issues regarding education, early childcare, preventive mental health, and so on, it seems a propitious time to pause momentarily and look backward in time to determine where we came from, how we got where we are, and upon whose shoulders we stand in order to gain our present perspective of infancy. In short, it seems worthwhile to undertake a brief historical journey in which we attempt to better understand our intellectual and conceptual forebears in developmental psychology.¹ It is with this goal in mind that I have written the present essay.

The Premodern Period: Antiquity to the 19th Century

The current scientific and cultural belief of Western civilization that the infant and child are not just miniature psychological replicas of the adult is of relatively recent origin (Kessen, 1965; Murphy, 1932). We conceive of infancy and childhood as a qualitatively special or separate state which is adaptively distinct, and which follows different psychological rules, obeys different neurobiological laws, and is organized according to different guidelines from that of adults. Although such a view has been slowly developing over the past 400 years, it is nonetheless true that prior to the latter part of the 19th century, Western society (including intellectuals and scientists) would have found our present concern for, and the attention to, early behavioral development odd, indeed.

Perhaps one of the most pervasive and long-lasting philosophical views of infancy and childhood in Western civilization, particularly with regard to educational training, is the Greek view, primarily formulated by Plato and Aristotle, that prior to the onset of reasoning — thought to begin at about age 7 — any attempts at formal education or systematic training are a waste of effort. Although the Roman educator Quintillian in the 1st century A.D. expressed the opposite view that systematic education of children should begin in infancy, the Platonic approach proved to be more appealing of the two, and consequently it dominated our conception of infancy, childhood, and early behavioral development for centuries.

During this long period of unenlightenment, even the children of the privileged classes were apparently provided with little more than caretaking attention, usually ministered by slaves or servants, whereas among the poor, due mainly to the high rate of infant mortality, it was necessary for a child to prove itself by surviving for a few years

before even a minimal amount of attention was directed toward it. Even after having survived to 6 or 7 years, however, the child was seldom dealt with as a special or unique person, but rather was immediately looked on as a small adult. Consequently, children were quickly forced into the adult world of work, play, sex, and early death (Aries, 1962; Hunt, 1970). Such a conception of the period of infancy and childhood was obviously not conducive to inquiries into the nature of behavioral development.

Although already by the close of the 17th century this view of childhood was noticeably changing (at least among the better educated, e.g., see John Locke's *Some Thoughts Concerning Education*, 1693/1947), with the exception of the demographic fact of an increased survival of young children, which apparently led to more consistent parent-child relations (e.g., Mazlish, 1975), so far as I know the reasons behind such a change of attitude have never been satisfactorily explained. Aries (1962), however, argues that the growing influence of Christianity may also have been an important factor by stressing the duty of adults to safeguard the innocence and weaknesses of childhood. In any case, the changing view of infancy and childhood that began to emerge during the 17th and 18th centuries is perhaps nowhere better exemplified than in the writings of the French philosopher Jean Jacques Rousseau, especially in *Emile*, or *On Education*, originally published in 1762. For perhaps the first time in history we find an influential intellectual such as Rousseau strongly espousing the view that the child was qualitatively different from an adult (Kessen, 1965; Piaget, 1971). Childhood, according to Rousseau, is a time important in itself, a time when the behavior of the child is appropriate to the demands of his needs and his world. In *Emile* one learns that the child by nature is good, not evil; nature is good, society is bad, and the child is part of nature. According to Rousseau, nature endowed the child with an order of development that ensured his healthy growth. Adult supervision, education, etc. must all be subservient to, or be carried out within, the framework of the child's natural development. As has been pointed out by Claparede (1912, as cited in Kessen, 1965), in *Emile*, Rousseau also directly or indirectly discussed many of the issues that were later, and still are, of great concern to child psychologists. For example, in *Emile* one can find the idea expressed that the child develops naturally by passing through a number of stages that follow one another in a constant sequence; or that in order for behavior to develop normally, it must function or be exercised during development; and that the function of an early behavior may be necessary for the development and full manifestation of a different later-appearing behavior.

Thus, in Rousseau's *Emile* we find not only an eloquent reflection of the changing views of childhood in Western society, but also a substantial impetus for further changes in the same direction. It seems quite likely that the rather revolutionary ideas expressed in *Emile* were partly responsible for the onset and recurring appearance of the often rather anecdotal, but nevertheless historically important, biographies of infancy and childhood kept by curious parents (see Dennis, 1949, for a historical treatment of these). Such biographies, in turn, were the forerunner — indeed the foundation — of more systematic scientific investigations of behavioral development in children (e.g., Piaget).

In spite of these encouraging harbingers of a changing view of childhood, it wasn't until the last half of the 19th century that scientists, intellectuals, and society began to seriously challenge the earlier concept of infancy and childhood as a period of rather little interest or importance. Dramatic examples of this change can be found in the first appearance of popular novels whose main characters were children (e.g., *Oliver Twist* and *David Copperfield* published by Charles Dickens in 1838 and 1849, respectively),

and in the first serious concern expressed by politicians for the welfare and protection of children. Lord Shaftesbury (Anthony Ashley-Cooper), in particular, devoted much of his professional life to helping establish laws for the protection of children from the abuses of parents and of factory and coal mine operators, all of whom frequently saw nothing wrong with sending children to work at the age of five (see Battiscombe, 1975). It is interesting that Dickens and Shaftesbury were contemporaries and in fact are known to have influenced one another's concern for the plight of children in 19th-century England (Johnson, 1952). Perhaps Shaftesbury best summarized the situation that then existed when he stated, "It would often be better if children had no parents at all!" (1868, p. 249.)

The Modern Period: Darwinian Influences

Although, as we shall see below, Charles Darwin's biological theory of evolution and natural selection directly influenced psychologists, such as G. Stanley Hall, to become interested in developmental phenomena, Darwin was himself interested in embryology, psychology, and behavioral development and thus he may well have had an even more direct influence on developmental psychology than that which occurred through his theory of evolution. Darwin was one of the earliest biographers of childhood. He completed a detailed diary of the development of emotions in his son William in 1840, although it wasn't published until 1877 in *Mind*, following Darwin's noticing a similar child biography published by Taine in the same journal.

Kessen (1965), in his excellent little essay on the history of child psychology, has concluded (and I would agree) that the primary influence of evolutionary theory on the history of child psychology was the infusion of the idea that the child was a legitimate subject for scientific investigation. Due primarily to the biogenetic law of Haeckel and Darwin, the development of the human embryo, fetus, infant, and child were thought to recapitulate, in modified form, the evolution of man. In other words, the ontogeny of man was viewed as the key to attaining a fuller understanding of man's vertebrate ancestors. That the biogenetic law as formulated by Haeckel and incorporated into evolutionary theory by Darwin was shown to be false as a general principle (de Beer, 1958) should not detract from the fact that it, nevertheless, focused attention on ontogeny and thereby hastened the advancement of all disciplines interested in development, including psychology.

One of those influenced by Darwin and Haeckel was the physiologist Wilhelm Preyer. Probably more than any single individual Preyer can be credited with having established the foundation for modern child psychology. In his monumental two-volume treatise *The Mind of the Child* (1888-1889), Preyer presented a systematic classification of his observations on the development of motor activity, sensation, perception, language, emotion, and cognition. *The Mind of the Child* established a methodological and conceptual framework which was to be influential for many years in the new discipline of child psychology. It was a framework which was biological in tradition and orientation, and which once again, after a hiatus of several decades, has recently experienced a vigorous resurrection, primarily through the efforts of the Swiss child psychologist, Jean Piaget.

Virtually unknown to most English-speaking psychologists, Preyer is also considered the father of behavioral embryology, the study of behavioral development prior to birth in animals and man (Gottlieb, 1973; Hamburger, 1963). He was of the opinion that "the fundamental activities of the mind, which are manifested only after birth, do not originate after birth" (xii, 1888). Preyer himself studied the reflexes and behavior of

many different vertebrate embryos and fetuses and published his observations in a still largely untranslated book entitled *Specielle Physiologie des Embryo* (1885). This aspect of Preyer's work has had an almost continuous influence on biologists and psychologists interested in early neural and behavioral development, beginning with Coghill, continuing through Windle, Carmichael and others, and culminating, for the moment at least, in the recent work of Hamburger and his associates (see chapters in Gottlieb, 1973). Perhaps one of the more enduring notions to have originated with Preyer is that of the primacy and importance of early motor activity for the later development of more cognitive-intellectual functions. This idea can be found in many subsequent developmental theories, including those of Freud, Werner, and Piaget.

Francis Galton, the cousin of Charles Darwin, was another scientist who was greatly influenced by evolutionary theory and natural selection to pursue developmental questions, although Galton's interests in this regard were manifested in an entirely different fashion from Preyer. Galton's primary contribution to child psychology was his steadfast belief in the importance of individual variation and his attempt to devise systematic and quantitative techniques for assessing it. He should also be remembered for his contributions to the question of the relative roles of "nature and nurture" in the achievements of prominent Englishmen. In particular, Galton foresaw the usefulness of comparing twins in attempting to systematically deal with this question. Galton's interest in the systematic measurement of psychological traits was in many ways a significant forerunner of the intelligence and child testing movements which began shortly after the turn of the century, both of which continue unabated to the present time.

Perhaps the most important person in the history of child psychology to have been influenced by the Darwinian biological tradition was the American psychologist, G. Stanley Hall. Although Hall is often only remembered as the man who brought Freud, Jung, and other prominent figures in the psychoanalytical movement to America for the famous meeting at Clark University in 1909, he has other more substantial contributions to his credit as well. For example, he was the first person to receive a Ph.D. in psychology in America in 1878. He studied with some of the foremost figures in 19th-century psychology and physiology, including James, Helmholtz, Wundt, and duBois-Reymond. And he was the founder and first president of Clark University. But more importantly for the present discussion, Hall was instrumental in establishing the discipline of child psychology in America. In a prodigious number of popular and scientific articles and speeches beginning in the 1880's and continuing up until his death in 1924, Hall was almost singlehandedly responsible for inducing a genuine interest in childhood and behavioral development among scientists and society (Ross, 1972). For this reason alone he deserves the sobriquet, father of child psychology in America.

Hall's own theory of behavioral development consisted primarily of an attempt to merge evolutionary theory, especially the biogenetic law and the neo-Lamarckian view of the inheritance of acquired characteristics, with psychological phenomena. One of the few lasting influences of Hall's theory of development, or psychogenesis as he termed it, was the notion of stages. To Hall behavioral development consisted of a predetermined sequence of stages, each of which represented a distinct and separate step in the evolution of mind. Like Haeckel, Hall believed that for mind and body alike ontogeny was a recapitulation of phylogeny. Hall also viewed development as occurring in abrupt, saltatory steps rather than by a gradual, continuous progression. Hall stated that the time during which a behavior was in the transition between one step

and the next represented a "critical period," a time when the behavior was most subject to environmental modification.

In the period between Hall and the present the two most influential and noteworthy persons in child psychology who carried forward the Darwinian biological tradition were Arnold Gesell and Jean Piaget. Gesell, who was a student of Hall, is most frequently remembered in historical treatments of child psychology as the proponent of a strongly nativistic, maturational theory of behavioral development. In my opinion this reflects an unfortunate and serious distortion of Gesell's actual conceptual contributions to child psychology, as well as an indifference to his substantial methodological and diagnostic innovations (Gesell, 1928). Conceptually, Gesell was the first child psychologist to recognize and actually incorporate into his thinking on development the findings and principles of modern experimental embryology. Only now are child psychologists once again recognizing the vast and rich store of facts and concepts which biology and experimental embryology have to offer to the understanding of behavioral development (e.g., see Bower, 1974; Kagan, 1971; Lenneberg, 1967; Trevarthen, 1973). For Gesell, "The action systems of embryo, fetus, infant and child undergo pattern changes which are so sequential and orderly that we may be certain that the patterning process is governed by mechanisms of form regulation — the same mechanisms which are being established by the science of embryology" (1954, p. 337).

Concerning Gesell's purported nativistic position on behavioral development, one can do no better than to allow him to speak for himself on this issue: "Growth is not an easily dissected function in which elements of inheritance are readily distinguished from factors of environment or training. The constitution and conditions of the organism are intimately interdependent. The organismic pattern of one moment, responsive to both internal and external environments influences the pattern of succeeding moments. Accordingly there is a very reciprocal interrelationship between heredity and environment" (Gesell and Thompson, 1934, p. 294).

Methodologically, Gesell introduced a host of laboratory and clinical techniques for studying infant and child development, many of which became the standard armamentarium of child psychologists. In my opinion, Gesell, more than anyone else in the history of child psychology, is responsible for conceptually and methodologically placing the study of child psychology on a firm and modern scientific basis. Perhaps with the present trend toward a greater appreciation of the role of biological principles in developmental psychology, he will get the recognition he rightfully deserves.

Because Piaget's conceptual approach to developmental psychology is basically rather similar to Gesell's and because, unlike Gesell, Piaget currently enjoys an enormous degree of popularity in child psychology, I have chosen not to discuss Piagetian theory in detail in the present context. (See the article in this volume by Dunst and Brassell). Suffice it to say that Piaget is in the biological tradition discussed above in that he recognizes the usefulness of biological and embryological concepts for developmental psychology, because he acknowledges the continuity of behavioral development, including cognition and intelligence, from the embryo to the adult, and because he views the behavior of the infant and child as possessing a remarkable degree of structure and organization with which it actively engages and modifies (assimilates and accommodates) environmental stimuli (Piaget, 1971).

Modern Period: Psychological Influences

In dichotomizing the modern period of developmental psychology according to whether a theorist is mainly in the biological or psychological tradition, I realize that I

have made a personal and somewhat arbitrary distinction. The reason for doing so is that I hope it will help clarify two rather different modes of viewing the development of behavior. The biological tradition that I have just discussed views the newborn child as an active organism which enters the world with a complex and highly organized nervous system that has developed during prenatal life according to well recognized rules and principles of embryology. And, while fully acknowledging the important role of the environment in both pre- and postnatal development, those in the biological tradition maintain that it is not possible to explain all of the patterning, differentiation, integration, and organization of behavioral development solely in terms of learning, conditioning, or other stimulus-response concepts. Rather than being a passive recipient of environmental input, the developing organism is viewed as actively imposing its own predetermined structure on environmental events, with the result that each new behavioral event develops as a unique product of the interaction of intrinsic and extrinsic factors.

The views expressed by those in the psychological tradition, on the other hand, being primarily derived from the associationistic views of Hobbes, Locke, J. S. Mill, et al., and subsequently embellished with principles of conditioning and learning, originally attempted to place almost the entire burden of behavioral development on the environment rather than on the child. The developing infant was looked on as a passive blank slate upon which the environment imposed all structure and organization in the form of stimulus-response relationships. Founded by J. B. Watson (1925), this "behavioristic" approach to child development was initially undertaken not to understand the nature of infancy, but rather to determine the extent of the innate behaviors present at birth in order to be able to state that, with the exception of these few simple instincts, everything else was acquired. Predictably, it wasn't long before "disciples" of Watson began arguing that even the simplest reflexes and "instinctive" movements of the newborn were acquired by prenatal conditioning *in utero* (Holt, 1931). Against this background it is hardly surprising that Gesell was considered a nativist and performanceist!

Due in part to the extreme statements of their own position, and in part to the growing strength of the proponents of the Darwinian tradition, the behavioristic approach failed to have a significant effect on developmental psychology until the 1950's (White, 1970). At that time, stimulated primarily by the intense interest within general psychology in the Hullian and Skinnerian modifications of behaviorism, learning theory models finally began to become more acceptable both as conceptual and methodological approaches to the development of behavior. Furthermore, Hebb's conceptual tour de force, published in 1949 under the title of *The Organization of Behavior*, was also an important factor in bringing learning theory approaches back into legitimacy in developmental psychology. By questioning the Gestalt position that most of our basic perceptual knowledge of the world is innate, and by providing a conceptual framework within which the relative roles of experience and maturation might be tested, Hebb initiated a line of investigation into the role of learning and early experience in behavioral development that continues unabated up to the present (Thompson and Grusec, 1970).

A third major influence in the contemporary approach to behavioral development was the Freudian theory of psychoanalysis. Being based primarily on the retrospective analysis of development by pathological adults, rather than on the direct study of development in infancy and childhood, the major influence of psychoanalytic theory on child psychology was the conceptual contribution of stressing the inordinate importance of early childhood years for the development of adult personality characteristics.

Ironically², in spite of the fact that Freud was of the general opinion that a science of human behavior must be based on a biological foundation, this aspect of his theory tended to lend support to the "psychological" (i.e., behavioristic) emphasis on learning and early experience, and consequently provided additional impetus to the growing trend of once again attempting to depict the newborn infant as a minimally structured blank slate. Early psychoanalytic theory differed, however, in that it was thought that the adult personality was rather rigidly determined during the first few years of life and that only formal, long-term intervention by a trained professional psychoanalyst could bring about even a modicum of change or reversal in personality following this early "critical period." Those in the "psychological" tradition accepted the unusual importance of early experiences but maintained that the adult personality was also the result of continuing environmental influences beyond the early critical period and that, in some cases, the later influences could even override the earlier ones. In other words, the two groups differed with regard to the stability or reversibility of behavioral characteristics established during infancy and early childhood.

Fortunately, before this rather immoderate "neo-behavioristic" trend had a chance to become the dominating conceptual framework in developmental psychology, the Darwinian biological tradition began to gain ground once again in the 1960's, due in part to the belated acceptance of Piaget in child psychology and in part to the growing popularity of ethological concepts in developmental psychology (e.g., Beach and Jaynes, 1954; Fantz, 1961). Thus, beginning in the 1970's and continuing up to the present time, developmental psychology has been characterized primarily by a largely successful merging and synthesis of ideas and concepts from both the biological and psychological traditions. As a result, developmental psychology, including animal development, has experienced the most productive and exciting period in its entire history. Indeed, if current trends are any indication, by the end of the present century we may be in a position to answer many of the theoretical and practical questions concerning behavioral development that for so long eluded that small but dedicated group of pioneers that preceded us.

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1. I use the term developmental psychology in its broadest possible sense to include the study of human (child psychology) and animal behavioral development and their neurobiological correlates.
2. Ironic also in that, although many psychologists viewed psychoanalytic theory as a pure nurture theory, Watson and the behaviorists rejected psychoanalysis as being too purely nativistic (see Shakow and Rapaport, 1964)!

The Case for Intervention with Impaired Infants¹

William R. Brassell
Western Carolina Center
Morganton, North Carolina

Infancy, a brief segment of the total life span, is increasingly acknowledged as a disproportionately important developmental period. For decades the psychiatric literature has linked adult emotional health to early childhood experience. Today behavioral scientists are concluding that other aspects of development are influenced by early experience as well. Not only social-emotional development, but also perceptual, cognitive, and motoric development are substantially, perhaps permanently, affected by events and encounters during the first two or three years of life.

Although the course of development appears to be determined by a myriad of complex, interrelated factors, few have been unequivocally identified. Nevertheless, the belief that the developmental course can be altered is so strong that early intervention with delayed and damaged children has become accepted social policy. A basic tenet supporting this policy is that development, if it can be facilitated at all, is more likely to be fostered in the very young child. Scientific justification for such a view will be presented in this paper.

The human infant is a remarkably adaptive organism. Because human behavioral patterns are not predetermined, the infant is flexible and capable of adapting to the demands of widely disparate environments. Although dependent, the newborn infant is not as incapable as was once assumed. A growing body of evidence strongly suggests that the infant is competent in many respects very early in life, if not from birth (e.g., Stone, Smith, & Murphy, 1973). Sensory information is processed; perception and discrimination are present; even learning occurs. Granted that most of the neonate's behavior is reflexive, the infant's responses become more and more adaptive during the first few weeks and months of life.

In the changed conception of infancy (see Oppenheim's review elsewhere in this issue), the baby is no longer portrayed as a passive recipient of stimulation, striving to maintain some comfortable biological or psychological state. Instead, the infant is seen as an active seeker of stimulation—an organism searching for, finding, and processing information. Such an organism, then, while it is in a period of exceedingly rapid growth, should be most malleable and sensitive to environmental change. Indeed, it has been suggested that "in terms of intelligence measured at age 17, about 50 percent of the development takes place between conception and age 4, about 30 percent between ages 4 and 8, and about 20 percent between ages 8 and 17 (Bloom, 1964, p. 88). Such a conclusion was drawn from a review of the available data from major longitudinal studies conducted over a 50-year period.

The Impact of Early Experience

The setting into which a child is born is a complex, unique environment for each baby. It can be conceptualized as a series of concentric circles with the infant in the center. Although the number of circles surrounding the infant could correspond to the precision with which one wishes to define the environment, it is limited here to three.

The inner circle is the baby's family or family surrogate, such as an institution, and it is this surround of influence which has the greatest impact among the three circles. It

cannot, however, be separated from the second circle that encompasses it—the family's socio-economic circumstances which touch and affect many aspects of the family's relationship with the baby. And the family's social class is embedded within a third concentric circle—a culture which varies from region to region and ethnic group to ethnic group.

Culture, social class, and family, then, are interrelated, and these combined postnatal environmental components interact with the infant's prenatal endowment: his sensory-neural system, his musculature, his capacity for learning, his propensity for displaying various social and emotional behaviors, his activity level, and countless other factors determined by heredity, the prenatal environment, and the birth process itself. The intricate interplay between the setting in which the child is born and his unique endowment at birth determines the baby's course of development. Precisely how individual factors interact and affect development is largely unknown.

The culture into which a child is born can also be thought of as a series of concentric circles, with each decreasing circle representative of a more narrowly defined cultural group to which the baby belongs. The American child is born into an English-speaking culture, an American culture, a deep Southern culture, a rural-coastal culture, and so on. Each of these groups has a tacitly agreed upon pattern of customs which becomes more specific as the social group is defined more narrowly. These customs have far-reaching effects upon the baby's development. It is generally accepted that differences between people from different cultures are to a larger extent due to the learning opportunities provided by these cultures than they are due to other potential differences, such as intellectual capacity (McCandless, 1967).

Differences in learning opportunities and subsequent effects are apparent even in early infancy, as illustrated by a study comparing maternal care and infant behavior in Japan and the United States (Caudill & Weinstein, 1969). This particular study typifies a relatively recent trend in cross-cultural comparison. The investigators tested specific hypotheses regarding child-rearing practices and development, as opposed to the traditional approach of merely describing differences.

A time-sampling procedure was used to observe 30 Japanese and 30 American mother-infant dyads in their middle-class, urban homes. The babies in each sample were three to four months old, and the two groups were equated on age, birth order, and sex. Individual differences in genetic effects and physiology were assumed to be randomly distributed within the groups.

Four observations were made per minute during predetermined periods of time, for a total of 800 observations per family. The observations indicated that the expression of the infant's biological needs and the mother's caretaking of these needs were the same in both cultures. Beyond expressing and meeting basic needs, though, there seemed to be significance differences between the two cultures:

The Japanese baby seems passive, and he lies quietly with occasional unhappy vocalizations, while his mother, in her care, does more lulling, carrying, and rocking of her baby. She seems to try to soothe and quiet the child, and to communicate with him physically rather than verbally. On the other hand, the American infant is more active, happily vocal, and exploring of his environment, and his mother in her care does more looking at and chatting to her baby. She seems to stimulate the baby to activity and to vocal response. It is as if the American mother wanted to have a vocal, active baby, and the Japanese mother wanted to have a quiet, contented baby. In terms of styles of caretaking of the mothers in the two cultures, they seem to get what they want. (Pp. 29-30)

Learning opportunities for the infant vary not only from culture to culture, but also among social classes within a general culture. In the United States, society is usually stratified into three broad classes, which in turn are often further subdivided. For the most part, researchers have concentrated on differences between middle class families. Although a family's social class can be determined in a number of ways, it does not seem to make much difference whether it is defined by a single factor, such as annual income, paternal occupation, or education, or by complex indices involving a number of factors (Caldwell & Richmond, 1967).

Measurable differences between children from relatively privileged and under-privileged backgrounds begin to appear on developmental scales between the ages of 18 to 36 months, and it has been suggested that significant differences would appear even earlier, provided that investigators knew what to measure. One investigator, for example, has demonstrated that the effects of social class differences can potentially be assessed in the first year of life (Tulkin, 1973). He found that middle class babies at the age of 10 months responded differentially to their mother's and a stranger's voices to a greater extent than did their "working class" counterparts.

Even though the disadvantaged mother is as concerned about the welfare of her infant as the advantaged mother and does not leave her child alone or neglect it to any greater extent, there are real differences in child-rearing practices. A major difference between poor and privileged children is in the comprehension and expression of language, perhaps because the disadvantaged mother engages in shorter periods of face-to-face talking with her baby and speaks with less variety, specificity, and complexity than the advantaged mother.

The disadvantaged child also seems to possess a less richly developed "mental set" for solving problems and understanding discrepant events. One of the possible reasons for this is that the lower class mother, unlike the middle class mother, does not play "theme and variations" with her infant. She does not, for example, play peek-a-boo with her baby and, as the child becomes bored, shift the position of her face or change her facial expression. (Kagan, 1970).

Significant differences in behavior patterns have been found between middle and lower class mothers (Hess & Shipman, 1965). Analyses of interpersonal behavior indicate important differences in maternal language and teaching style. Apparently the cognitive and linguistic stimulation afforded by the less advantaged mother is less adequate for optimal development (Coleman, 1966; Hess, Shipman, Brophy, & Baer, 1969). One indication of the relationship between maternal use of language and child development is the fact that language enrichment activities can affect the young child's use of language considerably. For example, simply reading stories to two-year-old children from low-income urban backgrounds can lead to a significant improvement in their vocabularies (Fodor, 1967).

Perhaps the crucial difference between the mothers from the two groups is that the disadvantaged mother does not believe that what she does really makes a difference in her child's development. Perhaps she tends to be fatalistic in that she assumes genetic potential and chance experience, over which she has little control, are largely responsible for her infant's development. As a result, she interacts less often and less consistently with her baby than her middle class counterpart. The advantaged mother does believe that her behavior affects her infant's development and she reacts accordingly (Kagan, 1970).

Cultural and social expectations are conveyed to the infant by a number of people, of whom the most effective communicators are the parents, particularly the mother while

the infant is very young. But more importantly, the family transmits unique information that transcends cultural and socio-economic circumstances. It is generally assumed that the infant's early relationships with its family have long-term, if not lifetime, effects. Social interaction with others, especially the mother, has an enduring impact on the quality of future relationships. Indeed, it has been suggested that the first social tie, the bond between mother and infant, serves as a prototype for all later relationships (Yarrow, 1967). The infant's attachment to its mother appears to underlie much of future social behavior, emotional adjustment, and, some say (e.g., Goldfarb, 1955), even cognitive development.

The relationship between mother and infant is a dynamic complex interchange that is affected by a multitude of variables, not all of which are intrinsic to the dyad. To be sure, "mothering" has profound effects in and of itself on an infant's development, but these effects are to a large extent intertwined with others. Observational and correlational studies have served in some measure to pinpoint effects of mothering in infancy, but many of our ideas about what constitutes "good" mothering are still speculative. Most of the available research indicates that development is not critically related to superficial caregiving practices, such as variations in feeding, nor to the sheer quantity of contact with the mother, but to more subtle factors (see Clarke-Stewart, 1973, for a review of the literature).

Infant behavior related to affiliation and dependency has been found to correlate significantly with maternal needs in the same areas (Caldwell & Hersher, 1964). Positive maternal attitudes toward close infant interaction has been related to positive infant development (Davids, 1968), and there is evidence that intellectual growth is affected by the emotional aspect of the mother's behavior (e.g., Bayley & Schaefer, 1964). It has also been shown that babies whose mothers looked, touched, held, or talked to them tended to explore new situations in proportion to their experience with stimulation (Rubenstein, 1967). These few examples illustrate that the mother's attitudes and personality characteristics in all probability affect her infant's behavior and development—regardless of whether the mother is viewed theoretically as a source of emotional satisfaction, as a mediator of environmental stimulation, or as a source of reinforcement.

Even the very young infant is an active shaper of his environment through the mother-infant dyad. The dyad is an interactional one, and the pattern of interaction that develops depends upon the unique contributions of both individuals. Consider crying behavior as one example of the infant's contribution—by crying, the infant, rather than the mother, initiates most of the early interactional episodes (Moss & Robson, 1968).

The cry brings the caregiver to a position where other types of stimulation the baby provides, such as visual and tactile, can be effective (Bell, 1974). If, however, crying is excessive, it can threaten or even break down the caregiver system. Similarly, playful interaction is unlikely to occur when crying reaches an inconsolable level. Thus, an infant who cries too much or too little may miss much of the parental interaction that serves as a basis for appropriate development.

Maternal behavior has been shown to vary with the infant's activity level and behavioral state (Levy, 1958). Infants, for instance, differ considerably in the amount of time they sleep (e.g., Korner, 1974). Infants who tend to stay awake should increase the amount of time available for contact with their mothers and could therefore expand their opportunities for learning. Given a benign environment, then, a high activity level could be an asset, but given a malign environment, the highly active infant would be more likely to experience rejection, frustration, and defeat (McCandless, 1970).

Other attributes of the infant affect its treatment and potentially its development in turn. Infants differ significantly in soothability (Korner & Thoman, 1972), and this propensity for pacification has an affect on the caregiver (Korner, 1974). The young baby's responsiveness to stimulation plays an important part in the developing the mother-child relationship, for the stimulation the mother offers her infant is specifically related to the infant's responsiveness in particular sensory modalities (Osofsky & Danzger, 1974). Even physical appearance may affect the baby's early social interaction, in that people, including mothers, are more inclined to attend and react to an attractive infant. As Tanner (1974) has succinctly put it, variations in subcutaneous fat, particularly in such strategic areas as the cheeks and bottom, may well affect the caregiver's responses.

Restricted and Enriched Environments

What is known about social, cultural, parental, and personal factors constitutes a convincing case that much of the child's developmental course is set very early. The effects of early experience upon development are illustrated by studies of environmental restriction within the first two or three years of life. These studies, especially the older ones, are open to methodological criticism, but, as a group, their findings suggest one fundamental principle: Prolonged deprivation of sensory-perceptual, social, or maternal stimulation can have devastating effects on development. Because these studies are not well controlled, it is not possible to specify cause-and-effect relationships. Babies deprived of the emotional aspects of mothering, for example, are in many cases concomitantly deprived of social and sensory stimulation.

One of the first studies of this kind was conducted by Spitz (1945, 1946), who systematically observed and tested two groups of infants, one reared in a prison nursery and the other in a foundling home. The babies in the nursery were fed, played with, and cared for by their own mothers who were delinquent girls. In the foundling home each infant was cared for by a nurse who also had total responsibility for six other babies. The foundling babies spent all of their time in cribs with no toys and with bed sheets hung over the railings; in effect, they were in solitary confinement up to the time they were able to stand in their cribs.

The developmental progress of the two groups diverged remarkably, and there were striking differences in mortality rates. Despite good medical care, 34 of 91 infants in the foundling home died of various causes within a two-year period, while there were only three deaths in the prison nursery. In contrast to the prison babies, whose mean developmental quotient (DQ) showed a slow rise and remained within the normal range, the mean DQ of the foundling children continued to fall until it reached the level of moderate mental retardation. Despite justifiable criticism of the study (e.g., Pinneau, 1955), it was pioneering and highly influential.

In another well-known series of studies Goldfarb (1945, 1947, 1949) observed matched groups of children, half of whom had spent most of their first three years in an institution before being transferred to foster homes, and half of whom had been placed in foster homes during early infancy. The investigator found significant personality and intellectual deficiencies in the children who had been institutionalized for three years, in relation to the other group.

In a more recent study, Dennis (1960) examined the motor development of children living in three Iranian orphanages. He found exceptional motor retardation in children from two of the institutions where babies were routinely kept in their cribs and handled

only when absolutely necessary.

But in the third orphanage where the babies were frequently handled and allowed to exercise, motor development resembled that of home-reared children.

There has been some success at preventing or ameliorating the effects of early deprivation. In some instances, general environmental enrichment or intensive one-to-one social interaction has been provided on a relatively long-term basis. Although the procedures have been successful, they are difficult to reproduce. So many variables have been applied simultaneously that it has not been possible to specify the relative effectiveness of each of the numerous enrichment factors. More often than not, the experimental treatments have not been recorded in enough detail to permit replication. In other instances, more specific types of intervention have been used, usually for briefer periods. These more tightly controlled studies have come closer to identifying experiences crucial for optimal development.

In a pioneering study by Skeels (1966; Skeels & Dye, 1939), infants with an average age of 18 months and average DQ of 64 were transferred from an orphanage to the care of mildly retarded women living in a state institution. Each of 13 children was assigned to a different ward, where they received a great deal of attention and general stimulation for about 18 months, after which time all but two were adopted. During this period, the mean IQ of the children increased almost 30 points, in contrast to a drop of similar magnitude by a control group who has remained in the original orphanage. After 30 years, the orphanage-reared children were either still institutionalized or dead, but all 13 of the adopted children were alive and self-supporting, 11 having completed high school and four having had one or more years of college.

In another study with institutionalized infants, the investigator herself provided the care for eight six-month babies (Rheingold, 1956). In all, the children in the experimental group received attention about 23 per cent of the time, according to time sample observations, in comparison to about 7 per cent for a control group which received routine institutional care. Another notable factor was the one-to-one attention given the experimental infants, as opposed to the control babies who received their care from a staff of 17 people. Although the infants exposed to intervention did not score significantly higher on developmental tests, they were considerably more responsive socially than the control subjects.

A short-term experiment in an Iranian orphanage did result in greater gains on infancy tests, relative to a control group (Dennis & Sayegh, 1965). The treatment was simple—for an hour a day for 15 days the children were encouraged to sit and manipulate objects.

Other short-term studies with relatively specific intervention strategies have also had positive results. In one study, institutionalized babies less than 12 months old received tactile stimulation in two 10-minute sessions per day, five days each week (Casler, 1965). The experimenter merely stroked the baby, speaking to him every 60 seconds. Relative to a control group in the orphanage, significant differences on developmental tests favored the stimulated babies after 10 weeks of intervention.

Another study of experimentally produced stimulation involved rocking institutionalized babies for 20 minutes per day for about 3½ weeks during the first month of life (White & Castle, 1964). The intervention resulted in a significant increase in visual attention to the environment.

These studies of early environmental stimulation and enrichment, among others (e.g., Moss & Kagan, 1964; White, Castle, & Held, 1964), clearly indicate that developmental blunting can be avoided. The children in these studies—usually

institutionalized and with apparent organic damage—could be considered at risk environmentally. On the whole, the animal data fit well with the human data, and studies of early experience with primates and lower animals have served as foundations for the work with humans. (See Thompson & Grusec, 1970, for a review of the animal literature.)

During the 1960's there was an upsurge of interest in intervention with another group of young children who could be considered at risk environmentally—children from families with incomes and living standards at poverty level. Typically these children were provided a broad spectrum of enrichment experiences for months or even years as a preventive measure. The objective was to avert the unfavorable effects of poverty on development. A variety of compensatory programs was designed for these children, ranging from small, local day centers to such a mammoth program as Head Start.

There were three basic varieties of compensatory programs: Those where intervention occurred in group settings (e.g., Karnes, 1969; Weikart, 1970), those where tutors instructed the children in their homes (e.g., Schaefer & Aaronson, 1972), and those where trained personnel intervened with both parent and child in the home (e.g., Gordon, 1971; Levenstein, 1970). In addition, there were programs which employed home visits in conjunction with group intervention (e.g., Beller, 1972; Klaus & Gray, 1968).

In general, the data from compensatory programs demonstrate that early enrichment produces impressive gains in the intellectual functioning of young children. However, a recent analysis of early enrichment effects leaves little doubt that the various intervention models are not equally effective (Bronfenbrenner, 1974). Although intervention in group settings often resulted in substantial gains, these gains tended to dissipate once the programs were discontinued. In contrast, the children in home-based programs whose parents were meaningfully involved in intervention not only increased their initial gains, but the gains persisted three to four years after the formal intervention programs had been discontinued. Thus, progress produced by parents, with technical assistance and emotional support from professionals, was much more "resistant to erosion" than progress produced solely by professionals. Furthermore, unlike group intervention, parental intervention was more effective the earlier it was begun.

Intervention With Impaired Infants

For both technical and practical reasons, intervention with biologically impaired infants and young children has been evaluated much less extensively than has intervention with socio-economically disadvantaged children (see, for example, Simeonsson & Wiegerink, 1975). Although several intervention projects for organically damaged infants have realized some degree of national prominence (see Haith, 1972), none have reported longitudinal data conclusively linking intervention strategies to durable developmental change. There have, however, been reports of significant gains attained over relatively brief periods of three to four months in service programs where each baby served as his own control (Barrera, Routh, Parr, Johnson, Snider, Cordsby, & Schroeder, in press; Brassell & Dunst, 1975). These studies involved infants with a wide spectrum of developmental disabilities exposed to intervention from a variety of disciplines.

The only reported studies of significant cognitive change with classical control groups involve low birth-weight or premature infants, who are by definition at risk

biologically. In one study premature infants were exposed to a program of visual, tactile, and kinesthetic stimulation for six weeks in the hospital nursery, then followed through the first year by weekly home visits intended to improve maternal care (Scarr-Salapatek and Williams, 1973). At four weeks and at 12 months of age, the stimulated babies exhibited greater progress on developmental scales than their unstimulated counterparts. In a follow-up study, one group of low birth-weight infants received a similar program of stimulation while in the nursery; a second group also received extra handling from their mothers; a third group was only tested (Powell, 1974). Again, the babies in the stimulated and handled groups performed significantly better on developmental scales than the babies in the untreated control group.

In a longitudinal study with somewhat older children, Kirk (1958) introduced intervention between the ages of three and six years to institutionalized and home-reared mentally retarded children, about half of whom were considered retarded due to organic damage. In comparison with similar children who were not exposed to the intervention procedures, the stimulated children showed significant increments in IQ scores. Indeed, for 70 percent of the treatment sample the increments ranged between 10 and 30 IQ points, in contrast to a decline in IQ scores for the comparison children. Just as remarkable, the gains resulting from the intervention procedures endured for several years during a follow-up period.

Summary and Conclusions

The studies with impaired infants and young children support the contention that early intervention can channel the handicapped child's development in a positive direction. Nevertheless, as a body of scientific literature, the evidence concerning handicapped infants specifically is, at best, sparse and inconclusive. The case for intervention with the damaged infant is strengthened considerably, though, when the available evidence is considered in conjunction with the child development literature and the results of intervention with the non-damaged child.

Both the child development and the early intervention literatures indicate that the environment has a great—if not the greatest—impact on the individual during his earliest years. Our knowledge of cultural, social, personal, and parental factors impinging on the infant strongly suggest that the course of development is set early. Once the developmental course is set, it tends to endure persistently although it remains flexible within limits throughout early childhood. Our knowledge of early restriction and enrichment leaves little doubt that environmental manipulation can have profound effects on the developing individual. Furthermore, virtually all the evidence converges to formulate one fundamental principle: Parents are by far the most effective agents of intervention (also see Carter's article in this issue).

Extrapolation from the organically-intact to the organically-damaged child should only serve to generate hypotheses. Unimpaired infants are not the same as infants who have defective gene material or have experienced some devastating accident or disease pre-, peri-, or post-natally. Indeed, there are enormous individual differences among biologically impaired babies. Where the intact infant's needs are apt to be global and homogeneous, the damaged infant is likely to require individualized intervention in specific areas of development. Unless the effects of these procedures are examined systematically and objectively, we can never be sure whether we are imposing meaningless treatments on handicapped babies and depriving them of meaningful ones. Until the evidence is forthcoming, however, it appears that we are moving in the

proper direction when we intervene early and incorporate parents meaningfully in our efforts.

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THE UTILITY OF PIAGET'S CONCEPT OF DECALAGE FOR THE CONSTRUCTION OF COGNITIVELY-BASED INFANT CURRICULA¹

Carl J. Dunst
Arlington County Department of Human Resources
Arlington, Virginia

and

William R. Brassell
Western Carolina Center
Morganton, North Carolina

Oppenheim's (this issue) excellent historical review of the changing perspective of how the human infant has been viewed within the context of his cultural heritage illustrates well where our thoughts have come from and the direction we have taken towards stressing the crucial importance of the early years of life. This changing perspective has not occurred in a void, but rather has evolved from sound theoretical and empirical information. Based on these data, the infancy period of development is now considered a critical one, a time where a scantiness or lack of specific environmental experiences might have long-term negative effects on the social and intellectual development of the child (Watson, 1966). This basic tenet provides the underlying assumption on which early intervention as a means for circumventing or preventing developmental retardation is based. Available information affords support for this opinion (see Brassell, this issue). The human infant is no longer considered a passive recipient of stimulation, but rather is viewed as an active participant in molding encounters between itself and the environment (Stone, Smith, & Murphy, 1973). This perspective of the human organism has in part been influenced by the work of Jean Piaget, a biologist turned developmental psychologist who stresses the active role an infant plays in acquiring knowledge. The utility of his theory of cognition has numerous implications for both analysis of behavior and applied usages (e.g., infant psychological assessment and clinical psychology). In terms of early intervention strategies, one particular aspect of his theory, the concept of decalage, seems especially useful for formulating a framework for devising a structural basis for constructing infant curricula designed to foster the acquisition of cognitive skills. The objective of this paper is to describe a system that utilizes the concept of decalage for this purpose.

The Concept of Decalage

Jean Piaget's theory of intelligence is rich in descriptions of the multi-faceted aspects of the emergence of cognitive abilities. A central concept within Piaget's system is that of decalage. According to Pinard and Laurendeau (1969), the phenomenon of decalage links together such structural constructs as hierarchization, integration, consolidation and structuring, key theoretical notions that combine to explain the concept of stage within a Piagetian framework. The general theme of the concept distinguishes between levels of achievements and areas of performance. For instance, it is often noted that an individual can across a number of branches of development (e.g., reading, writing, and

arithmetic) be functioning at quite different developmental levels (third, first, and second grades respectively). These distinctions between developmental progression (vertical components) and areas of performance (horizontal components) are described as decalages.

The concept of vertical decalage "... refers to the sequence of steps involved in the attainment of a given concept or formation of a given operation..." (Flavell & Wohlwill, 1969, p. 109). According to Pinard and Laurendeau (1969), this developmental progression leading to the achievement of a cognitive concept occurs through the process of stage integration. Attainment of a cognitive structure at stage S_3 for example, supposes the integration of the acquisition of the preceding stages S_1 and S_2 , not just a substitution for, or juxtaposition with them. Learning is not conceived as a sum total of isolated skill acquisitions, but rather as coordinations, elaborations, and expansions of skill achievements which integrate with each other allowing for attainment of behaviors at the next highest level of functioning. Piaget (1936) has described the ontogenesis of intelligence for the sensorimotor period of development as occurring through a six stage process beginning at birth and culminating in the ability to use symbolically indicative behaviors by 2 years of age. Each stage in this sequence has defining behavioral response classes which exemplify a distinct level of cognitive performance. Excellent descriptions of the six stage process can be found elsewhere (e.g., Flavell, 1963; Hunt, 1961). Both the attainment of the behaviors representative of each of the six stages, and the conditions that allow movement from one level to another are explained by the complementary processes of assimilation and accommodation (Piaget, 1970). Cognitive structures become established by the very nature of the accommodation an organism makes to environmental encounters, which in turn become assimilated to existing structures, or expand, change, modify, and elaborate new structures.

In contrast, the concept of horizontal decalage "expresses a ... difference between the ages of acquisition of operations that bear on difference concepts (or contents), but obey identical structural laws" (Pinard & Laurendeau, 1969, p. 130). For the sensorimotor period of development, Piaget (1936, 1937, 1945) has identified some eight different branches of skill acquisitions representing horizontal decalage, these being thinking skills, object permanence, operational causality, space, time, vocal imitation, gestural imitation, and play. Being highly related cognitive skill attainments, a definite parallel structural development for these different concepts can be established (Uzgis, 1973). Each of these different constructs emerges through the identical six stage integration process represented by vertical decalage, yet not necessarily at the same rate of development (Corman & Escalona, 1969; Escalona & Corman, 1967), nor with direct bearing on the acquisition of other formally related concepts (Hunt, 1974).

The Relationship Between Vertical and Horizontal Decalages

The above descriptions of vertical and horizontal decalages serve to emphasize a distinction between the *process* and *content* of cognitive growth, with process outlining the order of acquisition of cognitive development, and content detailing the range of possible behavioral response classes representative of cognitively related actions. As might be suspected, the interrelationships among the different horizontal branches of development are high with regards to the age of acquisition of related behaviors across the various decalages (Uzgis, 1967, 1973; Uzgis & Hunt, 1975). Yet Hunt (1974), Hunt, Paraskevopoulous, Schickedanz, and Uzgis (1975), and Uzgis and Hunt (1968) have

maintained that possible variations in the rate of acquisition in any individual horizontal decalage is possible as a function of cultural differences and/or experiences afforded within a culture. Hunt (1974) in particular has argued that vertical progression in any one specific branch of development can be modified independently of changes in other branches. On a number of occasions, Hunt and his colleagues (Hunt, 1973; Hunt *et al.*, 1975; Uzgiris & Hunt, 1975) have noted developmental differences between infants reared from birth to approximately six months of age in a hospital setting, but provided experiences to foster the early onset of visually directed reaching (White, 1967), and infants reared at home from middle class backgrounds afforded considerable verbal interchange between the children and their caregivers (Uzgiris & Hunt, 1975). The children furnished the enriched experiences in the hospital setting achieved top level reaching at 89 days compared to 150 days for the middle class group. This same middle class group however, showed signs of rudimentary imitation around 90 days of age, whereas White's subjects showed not even the earliest signs of vocal imitation. Hunt (1974) has also noted this same reversal trend for such highly structurally related concepts as vocal and gestural imitation for children raised in an orphanage, with gestural imitation emerging with little retardation, and vocal imitation failing to develop at all.

Flavell and Wohlwill (1969) addressed this issue of independence among various horizontal decalages in terms of horizontal transfer across different areas of performance as a function of both specific and broad experiences afforded during training sessions designed to foster cognitive skill acquisitions. They argued that although a broad range of experiences might result in a slower and more haphazard acquisition of cognitive concepts, the attainments occur on a broader scale, providing a better basis for achievement of higher level cognitive skills. In fact, Wohlwill (1966) has stipulated that the more specific training is in producing vertical progression for a given construct, the smaller the amount of horizontal transfer that will result. The contention that vertical progression in any branch of development can be modified independently of changes in other branches has received additional support from other studies (Brassell & Dunst, 1975 and in preparation; Corman & Escalona, 1969; Dunst, 1974a, 1974b, 1974c; Escalona & Corman, 1967). These findings have led Hunt (1974) to draw the conclusion "that there is not only plasticity in the rate of development in general; there is also a great deal of independent plasticity in the rate of development . . . (among the different horizontal decalages)" (p. 11).

The Utility of the Decalage Concept

Combined vertical and horizontal decalages form a matrix defining both specific levels of development, and individual, yet structurally related areas of performance. Vertical decalage is illustrated by six distinct stages of development (Piaget, 1936); horizontal decalage defining separate areas of performance (Uzgiris & Hunt, 1975). This distinction between the process and content of cognition has already been found useful for developing infant assessment tools (Casati & Lezine, 1968; Escalona & Corman, 1966; Robinson, Chatelanat, Spritzer, Robertson, & Bricker, 1973; Uzgiris & Hunt, 1975), instruments found sensitive in detecting developmental differences early in life (Wachs, Uzgiris, & Hunt, 1971). In addition, measures which distinguish between developmental progression and areas of performance allow for comparisons of either acceleration or retardation of development as a function of diverse environmental conditions of rearing (e.g. Hunt *et al.*, 1975; Uzgiris & Hunt, 1975). There appears to be

additional utility for the decalage concept as a theoretical framework for the development of cognitive based infant intervention procedures.

Strategies for Infant Curriculum Construction

Robinson (1970) has suggested that there are five essential considerations when developing guidelines for establishing early cognitive intervention procedures. He recommends that intervention begin early with carefully planned experiences, that considerable attention be placed on facilitating the precursors of symbolic and communication skills, that there be a relationship between the experiences being afforded and the level of the child's developmental abilities, that long range goals be defined for the intervention procedures, and the sequence of steps necessary to reach these goals be identified. The use of the decalage concept for curriculum design can provide the structural basis for employing and utilizing these suggestions. Since Piaget's theory stresses the importance of the early adaptations the infant makes to environmental encounters, early intervention to exercise the infant's ready-made behavioral schemata needs to occur in order for them to become functional cognitive structures (see Dunst & Didoha, in preparation). In addition, evidence also suggests that Piaget's (1936, 1937, 1945) descriptions of early cognitive skill acquisitions are the probable precursors to later intellectual abilities, including both symbolic problem-solving skills (Berlyne, 1965, 1970) and language abilities (Bricker & Bricker, 1974; Morehead & Morehead, 1974; Sinclair-de-Zwart, 1969, 1971, 1973). Hunt (1973) has even suggested that object permanence and vocal imitation constitute the most important sensorimotor precursors providing the structural basis for language acquisition, and some recent evidence appears to support this belief (Kahn, 1975). Hunt (1961) has gone to considerable lengths to detail the major ingredients necessary for introducing learning activities that will expand and/or change cognitive structures, central to which is the ability to identify the steps involved in attaining a given concept or skill acquisition, thus allowing learning experiences to be matched to the child's existing level of cognitive functioning. Toward this end, for example, Uzgiris and Hunt (1975) have expanded upon Piaget's (1937) six stage outline of the development of object permanence and have identified 14 separate levels of the concept. The very structural design of the decalage concept defines long range goals; that is, the attainment of a broad range of cognitively related behaviors (horizontal components) at stage six level of development (vertical components). The utility of the decalage concept for infant curriculum construction appears extremely useful since it outlines the steps involved in attaining a given set of concepts and identifies a series of individual branches of cognitive development.

An examination of available infant intervention procedures (see Dunst, 1973a, 1973b, 1974d, and in preparation), however, finds that few curricula are designed so that they meet the guidelines suggested by Robinson (1970). This appears to be the case primarily because most infant curricula are fabricated from infant developmental and intelligence test items, rather than being linked directly to theories of infant cognition. As a result, two inherent flaws become apparent. One is the lack of interrelationship among the intervention activities. Traditional infant developmental and intelligence tests assume no relationship between successive levels of performance (Uzgiris & Hunt, 1975), and therefore curricula based on these scales facilitate rather isolated behavioral responses which might or might not serve as a basis for acquisition of higher level cognitive skills. The second major shortcoming is related to the intervention activities

themselves. Since it has been established that infant intelligence tests are neither representative nor predictive of later intellectual abilities (e.g., Stott & Ball, 1965), deriving intervention activities from these tests cannot be expected to facilitate cognitively indicative behaviors.

Piagetian inspired curricula have been proposed to overcome these shortcomings. However, some place more emphasis on vertical decalage (e.g., Badger, 1971a, 1971b), while others stress the horizontal components (e.g., Bardwell, 1972). An elaborate translation of the decalage concept into a comprehensive system for both assessing and training sensorimotor skills has been devised by Bricker and Chatelanat (Bricker & Bricker, 1973, in press). They have constructed a matrix of both increasing complexities of behavioral response achievements and a series of individual branches of development (e.g., object permanence, spatial relationships, and gestural imitation). Their system stresses the range, sequence, and nature of instructional events that provide the basis for the acquisition of the cognitive prerequisites needed to acquire linguistic competences (Bricker & Bricker, 1973, 1974, and in press). A curriculum derived from this position is in the process of being developed (Robinson, Rothacker, Spritzer, Robertson, & Chatelanat, 1974).

The Western Carolina Infants' Program Model

At the Western Carolina Infants' Program², numerous attempts are being made to develop intervention strategies that can be used to facilitate skill attainments and behavioral responses across a broad spectrum of developmental areas (e.g., physical therapy, language development, and behavioral management). One area which has received considerable attention is cognition. A diagnostic-prescriptive-evaluation model for cognitive intervention has been devised which integrates various theoretical positions into a system for both defining and fostering a wide range of cognitively related behaviors. The position is referred to as a neo-Piagetian one, since other theoretical positions (e.g., Bruner, 1971, 1973; Hunt, 1961; Watson, 1966, 1967, 1972) have been incorporated and utilized as a basis for translating empirically validated theories of cognition into a scheme for intervention. Of all the positions, Piaget's concept of decalage serves as the "road map," if you will, providing a framework defining both the topography of sensorimotor skill acquisitions and the sequence of steps leading toward the attainment of symbolic responses. The six-stage process outlined by Piaget (1936) defines the vertical components, with the individual branches of sensorimotor development delineated by Uzgiris and Hunt (1975) defining the horizontal components.³ This framework forms a matrix of 42 individual cells, each of which has response classes that represent specific hierarchically arranged cognitively related behaviors. Assessment of the levels of functioning for each of the branches of development is accomplished with the Uzgiris and Hunt Ordinal Scales of Infant Psychological Development, which serves both as a diagnostic and evaluative instrument. From the results of an assessment, a profile of each child's developmental strengths and weaknesses can be obtained. Based on this programmatic diagnostic information, individually prescribed activities are developed to facilitate the acquisition of behaviors which build upon existing cognitive structures and thus integrate, expand, and form higher level structures. Movement towards the ability to engage in symbolic thought processes (primarily thinking) and to utilize symbols to represent persons, objects, places, and events (language skills) are the underlying goals of the intervention procedures (Dunst, 1974e). The development of a series of activities that can be used to

promote the attainment of the skills in each of the individual cells of the decalage matrix is the central goal in constructing the intervention strategies. A provisional form of the curriculum has been proposed which details prescribed activities in each of the cells (Dunst, 1974f). Subsequently, a framework for constructing future versions has been devised. Three major phases of intervention within the over-all curriculum have been identified.⁴ Phase one covers the first three stages of Piaget's (1936, 1937, 1945) sensorimotor period of development, the major objective of the cognitive intervention strategy being to transform the infant from a passive recipient of stimulation to an active seeker and manipulator of environmental information. Procedures to accomplish this goal have been formulated by integrating the contingency awareness theory proposed by Watson (1966, 1967, 1972) with Piaget's (1936) descriptions of secondary circular reactions; that is, behavior patterns which center on manipulation and control of external events. To attain this goal, Dunst and Didoha (in preparation) have outlined three levels of intervention activities encompassing four classes of behavioral responses which are designed to facilitate these skills.

Phase two of the intervention strategy will cover Piaget's (1936) fourth and fifth stages of development, the major objective being to foster the requisite behaviors for both thinking (Berlyne, 1965, 1970) and language (Bricker & Bricker, 1974; Morehead & Morehead, 1974; Sinclair-de-Zwart, 1969, 1971, 1973) skills. Phase three will outline an intervention procedure to integrate the symbolic response classes facilitated in phase two, the major objective being to transform the child's language abilities from stimulus-controlled to response-producing behaviors; that is, language which is on the one hand symbolically organized, and on the other hand used as a means for conveying a demand, message, experience, etc. to a listener.

The short-term effectiveness of theorizing, constructing, and implementing cognitive based intervention strategies in the manner described above has been demonstrated in a number of studies (Brassell & Dunst, 1975 and in preparation; Dunst, 1974a, 1974b, 1974c). However, only longitudinal studies will provide definitive information concerning the long-term effects of the intervention strategies. In addition, it will necessitate comparative studies with contrasting cognitively-based curricula to determine the relative efficiency of different intervention procedures in producing horizontal transfer across the various decalages.

Summary

This paper describes the utility of Piaget's concepts of vertical and horizontal decalages as a structural basis for constructing cognitive based infant curricula. The use of the decalage concept allows for a distinction between branches of cognitive functioning and distinct levels of achievements. This distinction, it is argued, is essential since individual areas of cognitive performance are relatively independent, intervention in any one branch of development having little or no effects in non-intervention areas. Strategies for curriculum construction are reviewed, and a model which utilizes the decalage concept as a theoretical basis for formulating cognitively-based intervention procedures is presented.

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¹Portions of this paper were presented at the region IX meeting of the American Association on Mental Deficiency, Silver Spring, Maryland, November, 1974.

²The Western Carolina Infants' Program is directed by Samuel Cornwell, M.D., PhD., as a unit of the Western Carolina Center, J. Iverson Riddle, M.D., Director. The authors are grateful for their support in all phases of development of the intervention procedures reported in this section.

³The branches of development are: I: The Development of Visual Pursuit and the Permanence of Objects, II: The Development of Means for Obtaining Desired Environmental Events, III: The Development of Imitation: (a) Vocal, and (b) Gestural, IV: The Development of Operational Causality, V: The Construction of Object Relations in Space, and VI: The Development of Schemes for Relating to Objects.

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THE DEVELOPMENTALLY INTEGRATED DAY CARE CENTER: A NEW CONCEPT IN EARLY INTERVENTION

Joyce Vonderweidt
Western Carolina Center
Morganton, North Carolina

The current research literature expresses an increasing concern on the part of professionals and parents alike for not only identifying, but also remedying developmental delays and other handicapping conditions at an early age. The major assumption underlying these activities is that many of the behavioral deficiencies and abnormalities usually associated with mental retardation and other handicaps can be ameliorated through early intervention, thereby reducing the need for subsequent special class placement and/or institutionalization. (The articles in this issue by Oppenheim, by Brassell, and by Dunst & Brassell review the bases for the notion that early intervention is more effective than later intervention.)

A number of studies have been reported over the past ten years assessing the progress of both mentally handicapped and normally developing children enrolled in early intervention programs (Caldwell, 1968, 1970). Virtually all of these efforts have been limited to serving either mentally handicapped or normally developing children. Only recently have researchers begun to ask the question as to whether the mentally handicapped child might not benefit from early exposure in an intervention program that serves both delayed and normal children (Bricker & Bricker, 1971, 1972, 1973). Henceforth in this article, I shall use the term developmental integration to refer to the placement of normal and delayed children (between the ages of 3 months and 4 years) in the same educational environment. This is a new concept in intervention programs and consequently one which raises many questions, not all of which are readily or easily answered.

The rationale behind these efforts at developmental integration is that normal children provide more appropriate behavioral and educational models for delayed children than is the case when delayed children contact only other delayed children or caregiving adults. Not to be overlooked are the potentially positive effects on adult caregiving staff behaviors when they are provided with the challenge to provide educational opportunities for children on a variety of levels.

There is some preliminary evidence suggesting that this developmentally integrated approach, when implemented in a half-way nursery school setting, results in enhanced developmental progress, as measured by objective standardized assessment tools for *both* normal and delayed youngsters (Bricker & Bricker, 1971, 1972, 1973).

The primary purpose of this program has been to establish, operate, and evaluate an early intervention program conducted in a comprehensive day care setting with an integrated group of normal and delayed children using an individualized curriculum approach for both groups. Due to the fact that each child functions at his or her own particular level of development, the need for individualized curriculums becomes readily apparent.

The major hypothesis has been that both groups of children, i.e. the normal and the delayed, will show developmental progress that equals or exceeds normal expectations based on standardized assessment instruments (Bayley Scales of Infant Development, Stanford Binet Intelligence Scale, Peabody Picture Vocabulary Test).

Any successful day care program for children practically insures the opportunity for each child to receive the appropriate physical, cognitive, and peer stimulation needed

for good growth and development. A day care facility which encourages parent participation in program planning and which combines delayed with normal infants and toddlers not only provides the opportunity for each child to have the physical, cognitive, and peer input she/he needs, but an added advantage in the area of social and emotional growth. We look forward to finding the normally developing infants and toddlers demonstrating observable gains in such hard-to-measure areas as persistence, patience, cooperation, trust, and leadership. With regard to the developmentally delayed children, it is anticipated that providing them with opportunities to interact at their own level with other children, some of whom are normal in their development, will prevent or reduce the development of those stereotypic or abnormal behaviors so frequently seen in institutionalized children.

As an outgrowth of this project, and in addition to providing an opportunity for the children to learn from peer modeling, it is expected that the delayed children will benefit by learning how to better function within a society that is mainly composed of normally developing children. Likewise, the normally developing child should benefit by learning how to function with a decidedly heterogeneous group of children, better preparing him/her to enter and participate with the wide age groupings found in many contemporary elementary schools.

Along with assessing the developmental progress of both the delayed and normal children, an attempt has been made to take a look (albeit informal) at the extent to which "downward modeling" occurs (i.e., copying of the less advanced behaviors of the delayed children by the normally developing children).

Day Care Program

Method

Each participant has been provided with an individualized curriculum covering seven areas of development for a period of four months. In addition, the developmentally delayed have been provided with intensive specialized programs carried out in an integrated subgroup. Three assessments have been conducted with each participant, with developmental progress before and after intervention being compared.

Subjects

The developmentally delayed participants for this project have been drawn from the clientele of the Western Carolina Infants' Program, which has been designed to serve children, from birth to approximately age 3 to 4 years, who have a wide range of developmental problems ranging from severe, multiple handicaps to mild problems or suspected future impairment. An attempt has been made to choose those children who would benefit the most from exposure to normally developing children. The selection of these developmentally delayed children has been, whenever possible, dependent upon their possession of some degree of imitative abilities, either gestural or verbal. The normally developing participants have been chosen from among Western Carolina Center staff families who have enrolled their children in the Developmentally Integrated Day Program.

The size of the program has been dependent upon the number of parents seeking day care placement for their children; presently this figure is 17. However, the rate of absenteeism, especially among the developmentally delayed, has remained quite high, due in part to what appears to be a higher than normal susceptibility to illness. In addition it has been found that the socio-economic level of the parents has an effect on attendance with those children from low socio-economic level families having a higher rate of absenteeism. Therefore, over-enrollment in a program which serves a large

proportion of families from low socio-economic levels is recommended. Over-enrollment has aided in maintaining the staff-to-child ratio at approximately 1:4.

Procedure

The Center operates from 6:30 a.m. until 5:30 p.m. during the five weekdays. The children arrive on a staggered basis dependent upon the needs of the families.

The schedule for the day is essentially the same for all children with the exception of the very young who require two naps per day. The morning begins with breakfast for those not fed at home (with children participating in the preparation), proceeds to free play at teacher-stationed activity centers, individualized activities with small subgroups of delayed and normal children selected according to the child's educational needs, lunch, nap, crafts, and free play. To insure adequate physical activity, every child gets out of doors for a portion of each day. Each child has his or her own primary caregiver. The philosophy is such that children are not initially assigned to caregivers; natural relationships are encouraged to develop. This hopefully allows for individual personalities and differing interests to blossom into positive relationships.

In an over-all view, the entire day is seen as the child's curriculum. Progressive intervention programs recognize the importance of incidental learning which requires caregivers to take advantage of every opportunity for instructing the child. This concept has the benefit of not limiting educational programming to a small portion of the day, but gives the caregiver the responsibility for providing an educational environment *throughout* the entire day. Caregivers are advised to be alert to those special moments when the child is particularly susceptible to learning a new concept, such as when the child is attempting to reach behind an obstacle to attain a toy (teach the meaning of the words behind versus in front), or teaching the meaning of hot and cold *while* the child is also learning to wash his hands. Caregivers are instructed in the concept that teaching a skill is facilitated by its relevance to the situation at hand and that learning is a continuous, ongoing process. Having caregivers alert to this assures opportunity for more frequent and relevant learning situations to occur.

The adoption of this philosophy requires that one also have a grasp on the importance of the physical environment with the understanding and appreciation of the necessity for it to be set in such a way so as to facilitate the optimal amount of educational stimulation, thereby enabling the child to progress smoothly from one activity to another as well as from one developmental level to another. The logical extension of this philosophy has resulted in the incorporation of the technologically based idea of changing the environment to change the child rather than presumptuously, and frequently unsuccessfully, attempting to change the individual through direct manipulation and thereby robbing the child of his or her individuality (Fuller, 1973). Permitting the child the integrity and trust to change and grow when he or she deems it relevant to his own growth and development as a feeling, thinking, and reacting human being is the direction in which relevant education is proceeding, regardless of the age of the child.

Lying within the framework of this philosophy is a more concrete curriculum which provides the factual basis of staff development and which serves as the caregiver's guide for constructing each child's daily activities. This is accomplished through the caregiver's maintenance of a developmental profile of abilities on each child. This profile is updated every four months by the primary caregiver. The areas in which the caregiver records the child's development include routine and self-help skills, environmental awareness, emotional development, language and cognition, gross motor skills, fine motor skills, and play behaviors.

Plotting this information on a chart in histogram form results in a profile of abilities exhibiting peaks and valleys for each child. Individualized activities are then selected by the caregiver to compliment the profile and set the stage for future development. Although there is emphasis on raising the valleys of the profile the peaks are not neglected, as it is in these areas where the child most probably achieves the greatest self-esteem. This type of curriculum has a large impact on staff development, as well as child development, as can be seen by caregiver's constantly being confronted with the task of locating present behaviors and looking for the next logical step in development.

By definition, an effective program will view each child, regardless of handicap, as a productive contributing individual. It is not taken lightly that the contributions of some children remain forever confined within the realm of eliciting only caregiving behaviors from those who have assumed the ultimate responsibility. As for those children who are more capable, it is remembered that even the most primitive of productions are of paramount importance to those who have produced them. Consequently, the arts and crafts produced by the children, no matter how simple, are of importance and regarded with respect. The finished product of a child represents a portion of himself, an expression of his unique individuality. Caregivers assume the obligation to see that children have ample opportunity to share these productions with those adults who have meaning to them.

Likewise, children are permitted to indulge their desire to contribute in other small courtesy, maintenance ways in that they frequently assist in their own food preparation and clean up. This gives added relevance to a curriculum concept which incorporates the entire environment.

The environment, which is interpreted as "everything which is not me," therefore includes the community at large. Preparation for functioning in this larger community is provided through short visits to observe community helpers at their tasks.

Other Program Components

Consultation Services

It has been stated that in caring for children, "unrelieved intimacy can be a depersonalizing experience, because there is the tendency to dilute the closeness by turning off the 'heavily amplified noise'" (McBride, 1974, p. 134). The acceptance of this statement in working with children makes one all the more grateful for the existence of specialized consultants who can be called in immediately for behavioral or educational consultation and advice. Each developmentally delayed child is assigned to one of the three multidisciplinary case management teams which comprise the Infant Program at large, and of which the day program is but one part. It is here where special assistance is provided in the areas of language development, behavior modification techniques, motor development, and physical therapy.

Team representatives, usually a teacher or nurse, make weekly visits to the day program to provide caregivers with special assistance in carrying out individual treatment plans. A team of physical therapists is available daily to carry out specific programs with those children, mainly the cerebral palsied, who require such services. A nurse and/or doctor is always on call for routine medical checkups as well as emergencies.

Graduate Student Involvement

Another component of the program facilitates local graduate and undergraduate students in their practicum experiences. On a part-time basis, they function in their area

of special interest as well as in the more general caregiving routines for the children with whom they are working.

Foster-Grandparent Plan

The Foster-Grandparent Plan has also become an integral and indispensable portion of the program. With training and guidance, foster grandparents fit in quite well and perform such duties as rocking, taking children for walks, providing one-to-one activities, assisting with feeding and crafts, and helping with maintenance routines.

Client Employment

The most recent attempt by the program has been to provide part-time employment for retarded and/or handicapped young adults who are attempting to make the transition from the protective environment of the institution to the community. It is expected that after a reasonable period of on-the-job training, these persons will become employable within the community.

Parental Involvement

Due to the fact that almost 100% of the participating children have working parents, the program has not been set up to have parents working in the Center on a cooperative basis. However, it is recognized that parent involvement is *essential* in the education of young children. Consequently, parent participation in educational programming is encouraged in the following ways.

For those delayed children who are receiving intensive training in the Center, it has been thought appropriate to have the parents come in for brief weekly sessions to enable them to observe the programming which the caregiver is carrying out with their child. This provides an opportunity for both parents and caregivers to ask questions of each other pertaining to more efficient methods of working with the child. The parents are also encouraged to work with their child directly at this session to insure that the work they are carrying out in the home is consistent with the programming being done at the Center.

Every child has his/her own copy book which is kept in the child's "cubby." Each caregiver is obliged to write in her child's notebook at least twice a week. The notes written in this book tell what the child has been doing, what appear to be his favorite activities, how he is getting along with others, and new friends he has made.

New programs and activities are also communicated through the use of this notebook. The parents are encouraged to write comments of their own into these notebooks and to take them home regularly to share with other family members. The response to this type of caregiver/parent communication has been unanimously favorable. Parents appreciate and are stimulated to work with their child when they are given the opportunity to see in writing what it is their child is doing at the Center. Caregivers serve as surrogate parents; therefore, they also are not immune to the reinforcement value contained in a written note from the parent. For this reason, parents are encouraged to write down their own thoughts in an effort to maintain a mutually beneficial running dialogue between parent and caregivers. This is an additional method to insure that activities which are going on in school can be complemented with activities in the home. An example of the effectiveness of this method is illustrated by the following excerpt from one of the childrens' notebooks:

Caregiver's Comment:

Susie keeps saying new words everyday! She will try to repeat almost all of the words I ask her to. Today we worked on a new toy — a shape box and Susie put all the shapes

in the correct place with just a little help. She is still working hard with the puzzles and is pointing to lots of pictures in books.

Parent's Comment:

We were both interested in the copy of Susie's new program. We were also amazed that some of the things such as: naming objects, letting her ask "what's that" (which she does frequently), and getting her to follow directions were things we were already doing at home. We haven't purchased puzzles for her but will do so very soon.... She knows so many words and seems to remember what things are after told. One thing she enjoys doing at home is writing. She often asks for paper and pencil.... She has a shape ball with different shapes and is learning to do all the shapes with a little help.

I have enjoyed the two Parent Programs and look forward to the next one.

Almost every parent has written comments back to the caregivers containing their ideas, suggestions, feelings, and questions. It appears that this is an extremely satisfactory method for increasing the involvement of working parents with their children.

Involving the parent in the pick-up and delivery of children is seen as part of the program. Parents are discouraged from merely dropping their child off at school. They have been requested to assist the child in removing his outer clothing, putting his belongings in the proper place, and in talking informally with caregivers.

It has been found necessary to request that parents bring their children to school fully dressed, some of them having previously brought their child directly from the crib to school. However, there is the need to constantly keep in mind the burden under which some families have to function. Working hours are long, their positions frequently physically demanding, travel time excessive, and incomes, in many cases, inadequate. A day program needs to be extremely sensitive in its handling of parents in an attempt to achieve that often delicate balance between the home and day care program. Occasionally, there are families who need assistance in understanding and accepting priorities. Consequently, the role of a social worker is an important one in the operation of the day care facility.

Parent meetings bring the parents and caregivers into close contact for group communication regarding the children. These meetings are held on a bi-monthly basis, late in the afternoon (as many parents are on shift work) in a large comfortable building away from the Day Care Center, but on the Center grounds. Invitations are printed and mailed directly to the home, refreshments served, and the children almost always in attendance. Past programs have relied heavily on outside speakers with typical topics being *Choosing Books for your Child*, *Choosing the Right Toys for Christmas*, *Making Toys at Home*, *Revving Up Your Child's Motor System*.

It is expected that by maintaining high parent/caregiver contact, parents will become more alert to not only the physical but also to the pre-academic needs of their children and thereby become more aggressive in assuring that these needs are met.

An effective program requires parents who are, at the least, somewhat "academically aggressive" for their children. Academically aggressive parents go a long way in assisting a program to constantly remain on its toes in providing each child with his or her own particular needs.

Day care staff attempt to give an air of importance to these meetings by treating parents with special undivided attention. By demonstrating a special concern for the parents, it is hoped that parents will model this behavior and demonstrate more concern for the development and education of their own children. It is suspected that there is the tendency for caregivers to lessen their interest and emotional involvement in those children who have parents who are not interested in their own children. Conversely, we

expect that by increasing interest in the parents, as well as in the children, we are encouraging parents to become more involved with the away-from-home education of their own children.

The last component of parent participation involves the Infants' Program "home visitor." For some of the delayed children in the group, it has been deemed appropriate to maintain the once-a-week home visit, which is carried out by an Infants' Program home visitor under the direction of one of the interdisciplinary teams. It is here where the parents receive additional instruction and assistance in coping with the educational and behavioral needs of their developmentally delayed child.

Program Evaluation

An effective program for children does well to have a method of program evaluation included as a regular policy. This insures that evaluation is an ongoing part of the curriculum and not something done occasionally or on a "one shot" basis. Curriculum goals can then more easily and justifiably be changed, modified, or eliminated.

In accordance with this belief, program evaluation has been included from the very start. Aiding in this effort has been the opportunity to assess the majority of children before their entrance into the program. It has therefore been possible to determine a rate of development before day program intervention using standardized assessment tools such as the Bayley Scales of Infant Development and the Stanford Binet Intelligence Scales. These rates of development have been computed over a period of time, averaging four months, and have been compared with a rate of development computed over an equal period of time after day program intervention. This process continues every four months for each child participating in the program. Parent conferences with a written evaluation are then held to bring parents officially up-to-date.

Non-standardized methods of program evaluation are accomplished through the use of the Uzgiris-Hunt Sensori-Motor Assessment. This assessment is utilized for highly specialized programming and is done only on those children in need of special education.

The seven-area curriculum guide previously mentioned is also used informally by caregivers in an attempt to assess their own techniques and observations, as well as to detect those subjective and subtle intra- and interpersonal changes in behaviors of the children which standardized assessment tools do not pick up.

It is expected that this built-in and ongoing method of program evaluation will insure the best possible tailored curriculum for each child, as well as aid in on-going staff development. The primary goal of this method of program evaluation has been to insure that each child has the opportunity to develop to his fullest potential.

Results

Although the project is rather young (one year of operation has not yet been completed) and has been beset with the problems of both unusually high absenteeism and child turnover rate among the delayed group, an attempt has been made to assess whether this type of intervention can serve as an appropriate adjunct to the straight home visiting model and/or as an alternative to those programs which segregate the young mentally and physically handicapped from the general population. The conclusions of those associated with this program are that it has been successful. However, this is not meant to imply an unqualified success. There is some indication that those children who fall within the categories of severe retardation (IQ 20-35) and profound retardation (IQ < 20) (Robinson & Robinson, 1970) do not make categorically measurable progress in a program such as this. Although there was the initial attempt

to pick children who would most likely benefit from a developmentally integrated educational environment (i.e., those with some imitative abilities), we were given the opportunity (due to periods of low enrollment and/or high absenteeism) to include three children in the severe to profound category. The developmental progress of these children is as follows:

Child	Retardation Category Before Intervention	Retardation Category After Intervention
1	Profound	Profound
2	Profound	Profound
3	Severe	Severe

For those developmentally delayed children on whom we have a complete set of data and who were initially assessed as being in the higher three categories of mental retardation, borderline (IQ 68-83), mild (IQ 52-67), and moderate (IQ 36-51), there have been more promising results.

Child	Retardation Category Before Intervention	Retardation Category After Intervention
1	Moderate	Mild
2	Moderate	Mild
3	Mild	Borderline

Since then there have been additional developmentally delayed children added to the program, but the age of the program and the entrance dates of the participating children have precluded the opportunity to observe whether this trend will continue. However, subjective observations by parents and caregivers indicate that the initially higher-functioning delayed children are giving evidence of accelerated progress. Both the objective and subjective results have been encouraging enough to indicate that attempts at setting up experimental programs such as this for the developmentally handicapped are justified and worthwhile.

Initially there was some concern regarding the placement of normally developing infants and toddlers in an educational environment which included such a high percentage of developmentally delayed children. In accordance with that concern, a close watch has been kept on the developmental progress of the normally developing children. The periodic assessments indicate that all five of the original group of normally developing children have increased their developmental rate after intervention.

Another concern with regard to the normally developing children was that they might model the inappropriate or stereotypic behaviors of the delayed. In a few instances this was observed. However, all inappropriate "downward modeling" was of extremely brief duration. In each case, as soon as data collection was initiated on the downward modeling, the behavior stopped. It appears that certain normally developing children

will initially "try out" the stereotypes and then drop them, presumably because in normal development they serve no function and are not reinforced by either parents or caregivers. The downward modeling which occurred took the form of occasional head slapping, protruding of the tongue, and imitating the walk of a cerebral palsied peer, both at the Center and in the home. Parents were alerted to be on the lookout for these behaviors and to note them when they thought they were occurring.

One parent's comments were as follows:

. . . Susie began holding her tongue out not long after beginning the program but lately that has almost ceased. The other thing I detected was a jerking of her arms similar to what Mike does, but this has ceased, also...

This project has provided additional support to the claim that the very young developmentally delayed child is capable of learning through intervention, and that both normal and delayed children function successfully within an educationally integrated setting. With regard to the normal children, it has been learned that they are in no way hampered intellectually by being in close daily contact with a high percentage of developmentally delayed children.

The question of normally developing children making greater than expected gains in those "softer" and more difficult to measure areas of development, such as nurturance, leadership, trust, patience, and persistence, remains to be answered. However, now that it has been established that early intervention, both with delayed and normal children does meet with positive results, developmentally integrated programs such as this should serve as an impetus for those doing research in the area of emotional development of children.

Summary

A day program associated with a state institution for the mentally handicapped is described. Using an individualized curriculum approach with a developmentally integrated group of infants and toddlers, this program has demonstrated that early intervention can result in greater than expected developmental gains in those children who evidence moderate to mild mental retardation. The normal children participating in the program also appear to have made greater than expected cognitive progress. Downward modeling of stereotypic behaviors by normal children does occur, but it is of short duration.

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THE NATURE OF CULTURAL DEPRIVATION: THEORETICAL ISSUES AND SUGGESTED RESEARCH STRATEGIES

Craig T. Ramey and James J. Gallagher
Frank Porter Graham Child Development Center
University of North Carolina at Chapel Hill

A growing body of scientific and educational literature suggests that children from poverty backgrounds do not perform in school or on standardized measures of intelligence, or in later life at the level of their more socially advantaged peers (Edgerton, 1967; Hunt, 1968; Uzgiris, 1970). However, there are a bewildering array of factors in the ecology of poverty that might be the crucial causal factors or, alternatively, could be merely associated factors with no causal relationship at all. For example, there is probably a relationship between the age of the car the poverty level family drives and poor performance of the poverty children in school. The poor performance in school would not likely be remedied by providing a newer model car to the poverty family since the relationship is only associative rather than causal.

During the last decade the biological and social sciences have moved from the role of an observer of the events of poverty to the role of an intervener to do something to correct the conditions leading to poverty. It becomes even more important, therefore, that we conceptualize the true nature of the problem. If we are going to embark on another "War on Poverty," it is important that we understand the true nature of the enemy, or we will run the danger of squandering scarce public dollars trying to remedy associated rather than causal factors.

The Course of Development Retardation

The nature and origins of mental retardation that are not caused by organic injury or glandular problems have intrigued professionals for many years. Low mental functioning, not attributable to identifiable organic cause, has in the past been called *familial mental deficiency* and *cultural-familial* retardation. These terms have been replaced in public favor by the term *environmental deprivation retardation*. According to Grossman (1973) "environmental deprivation" refers to:

insufficient quantity, variability, redundancy or discriminability in the environment. Includes: *Cultural Deprivation*, a condition in which the general total environment surrounding the child is markedly inappropriate for teaching skills needed for coping with the general environment, even though appropriate for the subculture. *Maternal Deprivation*, a condition in which the infant receives insufficient, inconsistent, or inappropriate stimulation or care. (pp. 131-132)

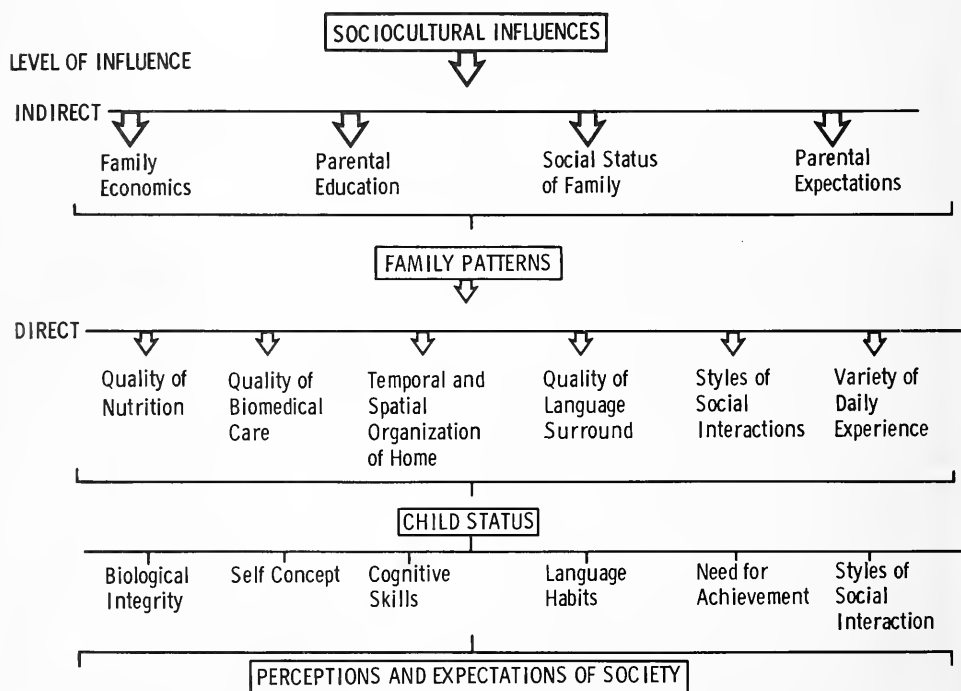
We can all observe the slow and steady pace in intellectual subnormality as these children grow older, fail in school, and become marginal citizens on the edges of modern society without agreeing on what the causes are or what the keystone variables are that can be manipulated to the child's benefit. Klineberg (1963), for example, sees the steady falling back of the slow learner as evidence of cumulative deficit. Jensen (1974), viewing the same phenomenon, finds the observations in line with his view of constitutional and genetic inferiority. The truth seems to be that the phenomenon of progress in retardation seems equally amenable to either theory in the absence of other supporting evidence.

The Causes of Developmental Retardation

Some of the possible causes of developmental retardation have been summarized by Chilman (1965), Robinson (1967), Hess, Shipman, Brophy, and Baer (1969), and Robinson and Robinson (1970). Among the factors thought to be important are the following: (1) low maternal intelligence, (2) emotional inadequacy of parents, (3) low level of achievement motivation of the family and subculture, (4) maladaptive family goals for children, (5) parental rejection, (6) limited financial means of the family, (7) low quality of the language environment, (8) inaccessibility of adults to reinforce new behavior patterns, (9) father absence or uninvolvedness, (10) racial and other differences which lead to discriminatory responses by individuals in the larger society, (11) unavailability of preventive or remedial instruction, and (12) poor quality of nutrition.

From the above list of possible etiologies, it is clear that some of these factors have a direct influence upon the child's status (e.g., quality of nutrition), whereas others have a more indirect and subtle, but perhaps no less profound influence (e.g., parental expectations for the child's achievement). In pursuing research aimed at revealing a general causal chain of influences (i.e., how molar variables become translated into specific practices or conditions), it is useful to make explicit the general relationships among these classes of variables. Figure 1 contains a schematic representation of a plausible causal chain.

Figure 1. Schematic diagram of relationships among differing levels of variables.



Strategies for Inquiry

As can be seen in Figure 1, the necessarily indirect relationships that exist between the levels of *sociocultural influences* and *child status* are mediated by the more direct variables labeled *family patterns*. Although the factors identified in Figure 1 represent only a partial delineation of all the possible factors which might result in low levels of performance, such an array at least serves to structure the process of inquiry into more explicit causal chains of influence. In this, as in other lines of research, two general strategies of investigation may be employed.

First, correlational studies may be conducted which attempt to link, either indirectly or directly, influential variables to measures of child status. In general, this method of inquiry is useful in generating hypotheses from a conceptually coherent network of information.

Second, once hypotheses have been generated and clarified, they can be brought under direct test by manipulative experiments. It should be noted that in our present model such *manipulative* experiments may be carried out by manipulating variables which are hypothesized to have either a direct or an indirect influence on the child's status. (This is the major thrust of our early intervention program at the Frank Porter Graham Child Development Center.)

Attempts to Accelerate Development

The decade of the 1960's marked an era of ebullient confidence in educators and social scientists that they could, given the proper resources, reverse the conditions of poverty and save countless children from a border-line existence with their new programs stressing new experiences.

That optimism has largely faded away. It is not so much that the innovators failed to achieve positive results, because they did. The unrealistically high expectations of the political supporters of programs such as Head Start, Follow Through, etc. just could not be met. Today's expectations are more sober and more realistic.

Two main approaches to designing early intervention programs have been tried. These are: (1) *developmental day care* where the child attends an organized group experience program in a specially designed environment, and (2) *home tutoring* where programs of parent training are brought to the home. Space prohibits a consideration of individual projects in this article. However, excellent recent reviews of the results from early intervention programs have recently been presented by Stedman, Anastasiow, Dorkecki, Gordon, and Parker (1972), Bronfenbrenner (1974), Ryan (1974), and Karnes and Teska (1975). These reviews argue that early intervention seems initially, at least, to benefit the cognitive development of disadvantaged children. However, they are also in agreement that relatively few measures of program impact have been taken and that relatively crude evaluation instruments have been used in even the better programs.

Several other tentative findings from the above-mentioned reviews merit reiteration. These findings include the following:

- (1) Structured programs produce greater intellectual gains than play-oriented programs.
- (2) Intellectual gains decline when active intervention is terminated.
- (3) Children from the most disorganized and deprived homes profit less from the programs and decline fastest when intervention is terminated.
- (4) Parent involvement in the educational process beneficially affects both the target

child and younger siblings.

(5) Parent involvement is most difficult to ensure in the most disadvantaged families.

At present there is an issue concerning the relative effectiveness of home tutoring versus developmental day care. However, there does not exist sufficiently comparable data to make direct comparisons between these two general intervention strategies.

If we wish to move from the level of general results to a more refined causative analysis and to test the relative effects of different intervention strategies, the use of intensively followed long-term longitudinal samples must be employed. Gallagher, Ramey, Haskins, and Finkelstein (1975) have pointed out that the nonlinear nature of development and changing interaction patterns of variables over time are potent arguments for using a longitudinal approach.

There are a few highly provocative longitudinal intervention studies, such as those done by Heber, Garber, Harrington, Hoffman, and Falender (1972), which suggest that intervention, properly done beginning at infancy, can do more than merely move the child from mental retardation to border-line performance, but can actually help develop an intellectually normal child. We need to know much more about the nature of such early child care programs and what the conditions are for normal development. The current authors are directing a major longitudinal study attempting to test some basic propositions on the crucial variables of poverty (Ramey, Collier, Sparling, Loda, Campbell, Ingram, & Finkelstein, 1975) through a longitudinal intervention program.

A Theoretical Basis for Early Intervention

In developing early intervention programs, it is necessary to clarify the theoretical underpinnings which support the endeavor so that coherent and communicable practices are insured. In this section we will briefly review the dominant positions which have guided previous intervention efforts and present the main ideas which are currently guiding the intervention program at the Frank Porter Graham Center.

If progress is to be made in separating relevant from irrelevant variables, much depends on the development of explanatory and predictive models of the developmental retardation process.

Jensen (1974) has presented two hypotheses relevant to cumulative deficit. He writes:

It has been assumed that the cumulative deficit in scholastic achievement occurs in many environmentally disadvantaged and minority children because at the time of school entry they have acquired fewer of the prerequisite skills for school learning than are possessed by the majority of their middle-class age-mates.

The counterhypothesis holds that the progressive decrement of low-socioeconomic status children is not in the main a matter of learning and transfer; but a matter of a different rate of development or a different growth function of the intrinsic maturation of cognitive abilities and their neurological underpinnings. (pp. 1002-1003)

As Jensen pointed out, these two hypotheses are not mutually exclusive. However, there does not appear in the literature adequate evidence to support comfortably either hypothesis.

Hunt (1968) has provided another possible set of explanations for cultural deprivation which centers on the concept of "intrinsic motivation." He maintained that just as there is an epigenesis in the structure of intelligence as discovered by Piaget, there is an epigenesis in the structure of *intrinsic motivation*. Further, it is the interruption of that sequence by the social and physical conditions of poverty that create the problems we

observe later in school performance.

The three major phases identified by Hunt are:

- (1) The infant is motivated by homeostatic need and painful stimulation. In this phase the child begins to use his schemata of sucking, looking, listening, vocalization, etc. to learn about the world around him. This stage comes to an end when the child tries actively to retain situations or circumstances which he has encountered repeatedly.
- (2) The second phase begins when the infant manifests intentional interest in what may be characterized as the newly familiar circumstances or situations which he has encountered repeatedly. Separation anxiety and separation grief appear to be special cases of the emotional distress that follow inability to restore the recognized circumstance.
- (3) The third phase begins with the appearance of an interest in novelty. The child not only imitates sounds, he creates new ones and fascinates himself in the process. This stage is marked by a strong increase in the variety of the infant's interests and actions.

With the development of interest in novelty the child has achieved the basis for "growth motivation."

Hunt concludes, therefore, that:

Cultural deprivation may be seen as a failure to provide an opportunity for infants and young children to encounter those circumstances required for adequate development of those semi-autonomous central processes demanded for acquiring skill in the use of linguistic and mathematical symbols and for the ability and motivation to analyze causal relationships. (p.39)

Our own viewpoint has a slightly different emphasis. We think that the characteristic responses of the poverty-reared child to either familiar or novel situations may not facilitate the development of that child. Any attempt to predict the probable response of a child to a given set of stimuli (e.g., an approaching mother, a new toy, the dinner bell, a light turning off, etc.) can be based on past responses to perceived similar stimuli. If the predominant reaction of the poverty-stricken child to the offer of a new toy is a fearful withdrawal, we would like to reduce that response and increase more constructive responses that could lead to the child's practicing various social and intellectual competences. We hypothesize that it is the daily practice of competences that is essential to full development.

Sequential experiences with the child lead to changed perceptions and behavior on the part of peer and adult observers. When the probability of a response reaches a certain level (let us say 80% probability), such consistency allows others to predict the child's likely response with some accuracy. For example, if a child when approached by another child will physically attack the newcomer with 80% certainty, the first child becomes identified as a hostile and aggressive child and tends to be avoided. If another child cries and withdraws in the face of novel stimuli, then others in the environment will tend to not include him in new or novel experiences.

In both instances the social perception of those around him may solidify the response patterns they perceive. The hostile and aggressive child who is avoided and shunned is likely to become even more angry and hostile, while the fearful child generally confirms and strengthens the fearful tendencies through avoidance mechanisms.

A consideration of the many specific dysfunctions which poverty-reared children exhibit has led us to hypothesize that relative inferiority in the areas of language development and motivation to learn are particularly detrimental to normal development.

Conversely, the presence of these adequately developed factors increases the probability that maximum development will occur.

The proposed role of language development in the developmental delay is hypothesized to operate as follows:

- (1) The development of a symbol system such as language enhances memory of past objects and events. It concretizes the social and physical environment of the child.
- (2) Language aids in establishing social communication. Needs and feelings get expressed and are more likely to be met, strengthening the parent-child affectional bond. (I'm hungry!; it hurts, Mommy!)
- (3) The availability of linguistic syntactical building blocks (i.e., connectives such as the verb "to be") increases the likelihood that the child will use these units to control his environment and not use more socially destructive alternatives (e.g., he will say "Johnny, you play with wagon; I play with ball" as opposed to fighting Johnny for possession of ball.)
- (4) Language can help the child anticipate the future and delay impulsive and destructive actions. (In a minute, Mary, you will have your bottle.)
- (5) The stronger the language development, the more likely the child will be receptive to preacademic activities such as being read to, forming letters, or looking at picture books.

In the area of motivation to learn (somewhat similar to Hunt's intrinsic motivation), we hypothesize that the following processes occur to generate or inhibit such characteristics:

- (1) The more the child experiences consistent rewards for his socially desirable actions, the more quickly he will learn particular responses.
- (2) The more varied the child's successful instrumental actions with things and people, the more successful he will be in new situations requiring similar responses.
- (3) The greater and more varied the child's successful instrumental actions with things and people, the more likely the child will be to explore his environment actively.
- (4) The greater the child's tendency to explore this environment actively, the more likely he will be to expand his repertoire by developing new responses and strategies when old ones are not successful in new situations.
- (5) Conversely, if the child's actions lead to no identifiable or consistent rewards, the child will lapse into greater passivity which will progressively result in less interaction with his environment and consequently in a more restricted repertoire.

The environment around the young child influencing his developing language and his expectations regarding reactions to behavior is being manipulated in a longitudinal day care situation at the Frank Porter Graham Center to provide the type of atmosphere our hypotheses lead us to believe will best facilitate the development of language and these expectations.

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Physical Therapy Services for Developmentally Disabled Infants: A Philosophy and Model

Judith J. Carter
Western Carolina Center
Morganton, North Carolina

In discussing the provision of physical therapy services for the young child or infant with a developmental delay or physical handicap such as cerebral palsy, two basic issues surface. The first is that of philosophy and the second that of a delivery model. At the present time professional opinion on philosophy varies from Phelp's bracing, to Doman-Delacato's patterning, to Neurodevelopmental Treatment (NDT or the Bobath approach). Each of these philosophies looks at development and the exceptional child slightly differently and recommends slightly different treatment regimes. In considering the different philosophies, the NDT approach seems to offer the most complete and neurologically sound treatment. It will therefore serve as the philosophical basis of the discussion of the evaluation and implementation of physical therapy services within one specific model. The term cerebral palsy will be used to refer to any neurological disorder due to damage to the central nervous system which leaves the child with abnormal movement patterns. The lesion is static (non-progressive) and is incurred any time from conception to about two years of age.

Traditionally, physical therapy services for a developmentally disabled child were offered on an outpatient basis at cerebral palsy schools, orthopedic clinics, and general hospitals, or as an inpatient service at residential centers. The child saw the therapist on a weekly basis. If a parent brought the child, they were usually asked to wait outside the room so the therapist could get the best possible performance from the child. Occasionally the parent was asked to do daily exercises, such as range of motion or stretching.

A second model was developed when the demand for therapists greatly outnumbered the supply. This demand gave birth to the physical therapy assistant or technician model. In this arrangement the therapist evaluates the child on the initial visit and periodically thereafter and plans a program and teaches it to an assistant who carries it out on a regular basis. This basic model is utilized in many of the residential centers in order to provide more frequent treatment for the resident.

In the process of establishing physical therapy services within the Infants' Program, a home based program serving infants under the age of three years, these traditional models were reviewed. To fully comprehend the decision that was made, it is necessary to have a basic understanding of the underlying philosophy of the Physical Therapy Department in the Infants' Program.

Traditional Treatment Approaches

Although little hard empirical research data have been published on any of the treatment approaches, bracing is probably the most commonly used method for treatment. However, it violates several basic principles of neurophysiology. First, it attempts to treat damage to the CNS by altering only the periphery. It works with the symptoms instead of trying to get to the cause of the problem. The second violation is that even in trying to correct the position of the muscles, it ignores the principle of the

stretch reflex within individual muscles. When a muscle is stretched, it automatically contracts to prevent overstretching or tearing of the muscle. In the case of a spastic child, this mechanism is exaggerated, resulting in excessive contraction or spasticity. When braces are placed on this child, the tight muscle is stretched to maintain proper alignment. This stretching causes the muscle to tighten even more.

Doman-Delacato report positive results with patterning, although little data are available for study and no reference is made to neurological principles, according to leading pediatric, neurologic, and orthopedic specialty societies (Doman, Spitz, Zucman, Delacato, & Doman, 1960).

NDT Approach

The NDT approach, however, is based on neurophysiological principles and those of normal motor development, and has given good clinical results for trained therapists (Pearson & Williams, 1972). This approach was originated about thirty years ago by Karl and Berta Bobath. It looks at developmentally disabled and cerebral palsied children as having two basic problems. The first is interference with normal maturation of the central nervous system, which results in motor retardation or delay. The second problem is the presence of abnormal patterns of posture and movement. Since the damage is usually to the brain and brain stem, the resulting disorder is mainly one of movement, its coordination and integration (Bobath, 1972; Bobath & Bobath, 1956; Finnie, 1974).

The aims of treatment are to increase or facilitate normal movement and decrease or inhibit abnormal patterns. The facilitation is done by guiding the motor output of the child by controlling the sensory input. The inhibition is accomplished by special handling techniques. All treatment is performed within the guidelines of normal motor development (Bobath, 1967; Semans, 1967).

Some basic assumptions are made utilizing the NDT approach. First, the child is a physical entity and as such moves in total patterns. The leg does not move in isolation from the rest of the body but rather affects the entire body with each action. Second, the child's physical development cannot be separated from the other facets of development, such as language, cognition, and emotion. (See Dunst & Brassell, and Oppenheim in this issue). Third, the child learns through all of his senses from experience, by being handled and touched in all activities of daily living. Normal movement is not possible without normal sensory experience, which is not possible without normal muscle tone. Fourth, the family has the primary responsibility for total care of the child, has the strongest relationship to the child, and is in the best position to effect significant change in the child.

At this time, no concrete data have been collected to support the NDT or any other treatment approach. This deficiency is primarily due to the difficulty in obtaining control groups, matching treatment groups, and finding truly objective measures of progress. There have been indications, however, that NDT is a viable treatment approach, and more concrete studies are currently being performed in Europe.

Inadequacies of Traditional Models

In working within this philosophical framework, the traditional models described previously seem inadequate for several reasons. They tend to deny the importance of

the parent-child relationship. They prevent the therapist from treating the entire child, and they try to intervene in one-half hour sessions without considering the home situation of the child.

In the early years the child is handled and trained mainly by the parents. Early activities such as feeding or bathing form the basis for later motor, cognitive, and social activities. Feeding is a foundation for speech, and bathing introduces the child to new sensations and to play or social give-and-take.

If a child has a physical handicap which makes this type of activity difficult, a real strain can be placed on the parent-child relationship. Parents often question their own competency as they feel constant failure. They can start to see truth in statements made by friends or professionals that institutionalization is the answer for "a child like that." They are putting in all the work of parenthood and getting back few of the joys. This situation creates the phenomenon of the "pathological parent." The mother tries to feed the child while he is tight or spastic. This tightness makes the feeding very difficult which is frustrating to the mother. The feeling of frustration is transferred to the child, at which point he becomes tighter and the mother has more difficulty. She may start to resent the child for creating feelings of inadequacy in her and her mothering abilities.

The pathological parent can also appear as the overprotective parent. This parent, when told of her/his child's handicap, is so protective that the infant never gets the usual practice necessary for further development. For example, if the child is hypotonic, the parent may tend to always support the head instead of producing better head control by slowly withdrawing this support. Spiraling pathological parent-child-parent cycles of increasing mutual frustration and dysfunction may be set in motion.

These parents need to be told how much they can realistically expect from the child, how to position and move the child so that he does not become stiff and more difficult to feed and how to play with and enjoy their child. When the parents understand realistic goals for the child and necessary techniques for reaching them, they begin to experience the desired positive feedback from the child and subsequently feel more secure and competent as parents, able to deal with their child and his handicaps. In turn the child can respond to the more positive feelings and has a better chance of meeting his full potential. This process is, therefore, good for the mental and physical health of both the parent and the child. The therapist must teach the parents these skills to provide the best possible environment for normal sensorimotor development.

A second basic problem of the traditional models is that they prevent the therapist from treating the child as a complete human being. The therapist ends up treating the physical disability alone without considering the cognitive, language, and socio-emotional elements. It is impossible and often unsuccessful to deal with one without confronting the others. Consider the child with poor head control. What does this do to the development of his sense of independence? How will it affect his cognitive development if in sitting it takes full concentration to hold his head up? What of the highly motivated child whose physical involvement prevents him from succeeding in tasks he knows how to do? Although physical therapists are aware of these other areas of development, they do not have the complete experience or education necessary to know exactly what is appropriate for any one child. It is therefore important to have professionals from the other developmental fields readily available as resources so a total treatment plan can be devised (Bobath & Finnie, 1973).

The third reason the early models seem inadequate is that they try to intervene with half-hour sessions without changing a child's lifestyle. This is basically the issue of handling versus treatment. If every time the parent handles or touches the child during

the week, he or she becomes increasingly spastic, there is nothing that can be done in one session a week to significantly change that child. The parents need to be trained to touch the child in a therapeutic manner. Then weekly treatment sessions become a supplement which allow the child to progress more rapidly. It is this kind of intervention which offers the most hope to the child.

The Therapist Role

Considering these three factors, the therapist's role in the Infants' Program has slowly developed. For most of the children the home trainer model is utilized. In this model, assessments are performed by a team of professionals, including a pediatrician, a nurse, a teacher, a communication specialist, a behavior analyst, and a physical therapist. At the assessment a home trainer is assigned and weekly visits to the family are initiated. In these visits, the families are instructed in the specific programs recommended by the team. In this manner the parents are made directly responsible for carrying out the prescribed programs with their child. The parent is the teacher and the therapist. The various disciplines integrate their programs and present them so that they can be accomplished within the normal activity schedule of the family. A clearer picture of the model may be obtained by following one child through the entire process.

A baby comes to the Infants' Program for an initial assessment. The physical therapist completes an assessment, as do the other members of the team. The P.T. assessment includes an examination of the child's muscle tone, his basic reflexes, and his over-all motor development. Not only are gross and fine motor age equivalencies derived, but qualitative statements on how the child performed each of the motor milestones are recorded. Observations are also made during the cognitive and language assessments to determine how the child's physical development is affecting these areas and how this stimulation and structure affects his physical status.

The team then meets to discuss the findings from the entire assessment and work out collectively the best total program for the child and family. Cross-disciplinary suggestions are frequently made. For instance, the teacher may be requested to do a fine motor program by the therapist so the child can better manipulate and explore objects. Or the communication specialist may request that oral normalization be included in the physical therapy program to prepare the child for the language programs being written.

The physical therapy programs most frequently consist of handling suggestions for the family. Suggestions as to how to pick up and carry the child are made and demonstrated. Good sitting positions are reviewed, as well as appropriate methods to use while dressing and feeding the child. Sometimes specific activities are suggested to encourage normal motor development.

Another type of program includes the use of adapted equipment. Frequently the child could perform better if he felt more stable and secure, so a chair or wedge is specifically designed for the unique problems of that child and is given to the family. Sometimes a splint or adapted spoon is made to help the hands function better. This adapted equipment provides a good alternate position for the family member who previously had always had to hold the child. In addition, it frequently increases the possibility of the child's advancing in cognitive and language areas.

When all of the programs from all the disciplines have been decided upon and the home trainer understands them all, an interpretive conference is held with the parents to explain the results of the tests and the type of programs they will be expected to carry

out with the help of the home trainer.

Before the home trainer makes the first weekly visit, he or she is given more specific oral and written instructions in how to carry out the physical programs. The programs may be tried out on a life size Raggedy Ann doll. This instruction is in addition to general workshops on handling and physical therapy programs which have been given to all home trainers. The home trainer then teaches the parents how to carry out these programs, giving them weekly feedback on how they are doing. The home trainer also reports weekly on the progress of the programs to the therapist. They report if there are any problems, such as the parents being unable to carry the child as suggested or physical barriers in the home which make the suggestions impractical. If something cannot be worked out between the home trainer and the therapist, a home visit for the therapist is arranged. Then the situation is fully reviewed and the necessary alterations made. The programs are also reviewed and changed when the child returns for reassessment every four months.

Direct Physical Therapy Services

Proper handling and home programs are not always sufficient for certain children; therefore, direct physical therapy services are also available for children who live close enough to make daily or weekly visits feasible. The service is offered in three basic ways. The first is by the regular treatment of all the developmentally delayed or cerebral palsied children in the day program associated with the Infants' Program. In this situation, both the physical therapy assistant and the home trainer participate. The parents still carry out home programs but are also invited to watch the daily physical therapy treatments to increase their understanding of the programs they do at home and to provide a good model of physical interaction with the child.

Outpatient physical therapy treatment is the second option for direct service. Once again, this treatment is not a substitute for what the parent does, but a supplement to it. The child and parent usually come on a weekly basis for intensive therapy sessions.

The third method available for direct service is to have the therapist or assistant serve as the home trainer. In this situation the therapist can give demonstrations and mini-treatments in the home in addition to all the other programming with the parents. The infants who usually receive this type of home visit are the younger, cerebral palsied individuals.

Case Histories

The following composite case histories are presented to demonstrate the different physical therapy models used within the Infants' Program and how they are modified for each child. They also illustrate the importance of the parents' attitude in determining the success of the programs. These histories concentrate mainly on the physical therapy aspects of the programs, omitting the cognitive, language, and behavioral elements. This is done not to decrease the importance of the team approach but rather to illustrate clearly the various methods of providing physical therapy services.

Don was seen initially by the Infants' Program staff at the age of 19½ months. He had been previously diagnosed as a multi-handicapped child secondary to infantile spasms. He presented as a severely retarded, possibly cortically blind child with spasticity and grand mal seizures.

Upon physical therapy examination Don was found to be severely spastic in the lower

extremities and moderately so in the upper extremities. He used the left side more than the right. He would not tolerate the prone position and in supported sitting fell to the right. His lower extremities extended stiffly if held in standing. Because many of Don's delays in cognitive areas were the result of his physical problems, the physical therapy assistant was assigned to be the home trainer. The assistant worked with the family on appropriate carrying techniques, positioning in prone and supine, and general handling suggestions. Specific programs included independent sitting balance, working on anterior and lateral arm support in sitting, and maintaining the all fours position. Cognitive programs included a tactile receptive program, an imitation program, and one in means-ends skills.

The home trainer reported that the parents were excellent handlers. Not only did they always move and carry Don correctly, but they demanded it of anyone else who touched him. They were also very diligent in carrying out the specific programs outlined by all of the disciplines.

The second assessment was not performed for six months following the initial because Don became very ill. Despite this prolonged illness, he showed marked improvement. He was now judged to be only mildly spastic. He showed no gross asymmetries, although he still preferred to use the left hand. He enjoyed the prone position and would go independently from prone to an all fours position. He could sit independently for several minutes. In standing there was stiff extension of the legs at first, but it slowly relaxed to a normal weight-bearing position. At this time a large crib was ordered for the home to accommodate Don's increasing size. The same cognitive and physical therapy programs were expanded and continued. During the next four months, Don continued to improve, although not as much as during the first period. He was now able to sit independently for 25 minutes. He had the beginnings of anterior and lateral arm support in sitting. He would rock back and forth in the all fours position. When held in standing he would bear full weight. The new programs now included a program for creeping, side-sitting, playing in prone, and range of motion exercises for the ankles.

It is felt that Don's over-all progress can be attributed to the parents incorporation of therapeutic handling into their daily lives and their diligence in carrying out the prescribed programs.

The second child, Barry, was 19 months old when he came to the Infant's Program for his initial assessment. He was diagnosed as having spastic diplegia with left hemiplegia, mild mental retardation, and a perceptual problem associated with oculomotor abnormalities.

At the time of the initial assessment, Barry's muscle tone varied from normal to mildly hypertonic. When under stress it increased to moderately hypertonic. He could roll and when prone could lift his head, although he had no forearm support. In supported sitting he rested on the small of his back. When held in standing, his lower extremities extended stiffly. The mother was noted to hold him in standing and move him forward to encourage walking. This activity increased his muscle tone greatly.

One of the Infants' Programs teachers was appointed to be the home trainer, and weekly visits began. The home trainer instructed the parents in carrying positions and appropriate play positions. They were also instructed to avoid any activity which increased his muscle tone, such as the walking.

At the second assessment, Barry was so tired and fussy that no physical therapy assessment could be performed. However, within the same month, Barry began receiving bi-monthly physical therapy treatments at a day care center in the community.

Barry did not attend the center full time but went only for his physical therapy sessions. During these sessions, he cried whenever removed from his mother's lap. It was felt that no progress was made. This arrangement continued for three months until the therapist working with him stopped serving that center.

Barry was not assessed again for eight months. At this time no progress was noted as compared to the initial assessment. In fact, he seemed tighter or more spastic. It was suggested that he might benefit from a day care program since the home programs were not having the expected results. In this way, Barry might also learn to separate from his mother more easily and could receive physical therapy on a daily basis. He entered the Infants' Day Program the next month. He received daily physical therapy in addition to cognitive and language programs. All of the day care staff were instructed in handling suggestions for Barry.

Four months later at Barry's fourth assessment, he demonstrated several new abilities, such as assuming the "puppy position" on his forearms and attempting to commando crawl. He still could not sit independently. The parents did not attend this assessment but sent Barry's teenage sister and one of her friends. The home trainer reported that she was beginning to feel that the parents were not carrying out the programs at home. They still moved him entirely too quickly and held him such that his abnormal patterns were accentuated. The home trainer felt that the father "spoiled" him because he could not stand to see him unhappy. The parents tended to leave much of the responsibility of care for Barry on the teenage sister or the babysitter. In fact, most of the home visits were made with the babysitter instead of the parents. At this time the parents withdrew Barry from the day program as they wanted him at home. They did agree to bring him in weekly for outpatient therapy. These weekly sessions included working on suggested cognitive and language concepts with being positioned in a therapeutically advantageous manner in addition to the regular physical therapy treatments. Behavioral programming was also utilized in the sessions to decrease his avoidance behavior.

Four months later, the final assessment was held. Once again his sister brought him to the assessment. Barry could now support himself on his forearms and commando crawl. He sat independently on the floor for several minutes and could sit on a small bench for 15-30 seconds. When placed in standing, he no longer demonstrated a total extensor pattern, instead hyperextended only the left leg.

Because this was the final assessment with the Infants' Program staff, a special interpretive interview was arranged with the parents a few evenings later. The findings were explained and some suggestions made. Barry's prognosis was discussed by the pediatrician. Future plans for education were mentioned as well as our staff expressing some fears we had for the family if primary care for Barry was left as the sister's responsibility. Continued outpatient physical therapy was arranged.

In reviewing Barry's progress, most of it can probably be attributed to maturation. Although the lack of proper handling by the parents cannot be said to be the only reason Barry became tighter and failed to make significant progress, it does seem to be an important factor. His case seems to illustrate well that the parents must be the primary therapist and that outside professional treatment cannot substitute for this vital component.

Summary

Physical therapy services for the developmentally disabled infant are provided in an unusual, possibly unique, way in the Infants' Program at Western Carolina Center. A home trainer is utilized to give the parents weekly instructions in proper handling and specific activities to encourage more normal development. In this type of approach, it is hoped the parents will become the therapists and integrate all the suggestions from all the different fields into the activities of the child throughout the entire day. This type of intervention may be supplemented by direct physical therapy treatments in one of several ways. The NDT approach is utilized in the model and seems to offer, within logistical limitations, the most complete physical therapy service for the developmentally disabled infant.

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**A Home-Centered, Regional Program
for Developmentally Impaired Infants and Toddlers:
The First Years**

Sam O. Cornwell, Ann B. Lane, and Caroline H. Swanton
Western Carolina Center
Morganton, North Carolina

The Western Carolina Infants' Program (WCIP) began operations in the late fall of 1972 as an outreach unit of Western Carolina Center, North Carolina's regional institution serving a special segment of mentally retarded from the westernmost 32 counties of the state. The goal of WCIP is to reduce the need for institutionalization by providing home and community-centered multidisciplinary services to delayed or handicapped pre-three year olds, usually through their parents. Objectives for WCIP have been to develop a high quality service-delivery model; to carefully evaluate the program, techniques, and services; and to assist communities in developing similar early intervention services. Planning for this program had proceeded intermittently since mid-1967 (Ferriz, 1971) under the leadership of Dr. J. Iverson Riddle, Director of Western Carolina Center, and Dr. Donald J. Stedman, Chairman of Infants' Program Advisory Committee, with important help from committee members and many other people. The specifics of the present service-delivery model were largely developed in latter 1972 by seven present and former WCIP staff members.¹ The senior author (S.O.C.) joined staff as director and pediatrician in December, 1972.

One of the three authors of this paper was team pediatrician (S.O.C., A.B.L., or C.H.S.) and did the diagnostic and other coding² reported herein for all but one of the 154 children and families admitted during the 2½ years of WCIP's existence up to July 1, 1975. Other WCIP staff collected much of the data.

Parents and surrogate parents have been the intervention agents ("teachers") for their delayed infant or toddler, guided by regular visits, usually weekly, from a WCIP staff member or a community agency member or volunteer. A person who, through regular home visits, guides parents in carrying out prescribed programs with their child is termed a "home-trainer." Multidisciplinary evaluation of the child and family is carried out at Western Carolina Center initially and roughly quarterly thereafter until the child reaches his third birthday or has been served for one year, whichever occurs last. Infants' Program staff, usually teachers or nurses, serve as home-trainers for families in the eight central counties within a 45-minute driving radius of Morganton.

Thirty-three community persons, often public health nurses or volunteers, have been recruited and are currently active as home-trainers for 39 families in more distant counties. Two-thirds of the first 154 children evaluated lived in the eight central counties, the other third in 17 more distant counties. Intervention programs in the various developmental areas (described earlier in this issue) are designed by Infants' Program staff in consultation with parents and home-trainers. Limited short-term residential and model day program services are also available.

Admissions, Organization, Staffing: Costs and Benefits

Home-training for three children and their parents was begun in the last quarter of 1972, 50 children were added in 1973, 60 in 1974, and 41 in the first half of 1975. On July 1, 1975, home-training was being provided to 91 children and families and 13 children were attending the WCIP Day Program (see Vonderweidt in this issue).

Infants' Program staff currently is organized into three geographic service-delivery teams, each serving 26 to 33 families living in nine to 14 different counties. Capacity is around 40 families per team. Each service team includes one social worker, one nurse, two teachers, a secretary, a part-time pediatrician, and a part-time psychologist. The "core team" provides specialized assessments, programs, and consultation. It includes two physical therapists, one physical educator, one language development specialist (a Ph.D. in psycholinguistics), one behavior analyst (a specialist in behavior modification), a physical therapy aide, a unit administrator, and a secretary.

It will be at least 1978 before effects can be determined of WCIP intervention on subsequent residential institutional placement of client children. The rationale and some of the effects of this intervention have already been described in the preceding articles in this issue. Some of the present and future value of WCIP is stimulating the development of early intervention programs for impaired young children and their parents and providing technical assistance for such programs. Operating costs are slightly above \$3000 per child-with-family served per year, ignoring indirect services such as technical assistance to other programs, roughly 50% above the cost of home-bound instruction for a "normal" elementary-aged child. Families pay a fraction of this cost through fees for evaluation and treatment (though not home-training) services determined by a sliding scale based on net income and family size.

Referral Sources

The largest source of referrals has been the staff of Community Mental Health Centers, particularly parent trainers, developmental day care center staff, and mental retardation specialists (see Table 1). Fewer cases were referred by community mental health staff in '74-'75, presumably due to increased awareness of WCIP by pediatricians, local public health departments, and specialized developmental evaluation, public health, clinics. Referrals from these three sources increased gradually from '72-'73 to '74-'75.

County Departments of Social Services were tied with Public Health as the third largest referral source.

TABLE 1
REFERRAL SOURCES

	% 1972 & 1973	% 1974	% First Half, 1975	% TOTALS
1. Community Mental Health Staff (Parent trainers, day care or mental retardation staff)	34.6	26.6	8.3	25.0
2. Pediatricians	5.8	15.6	25.0	14.5
3. Local Public Health	7.7	10.9	22.2	12.5
4. County Social Service Departments	17.3	12.5	5.6	12.5
5. Developmental Evaluation Clinics		14.1	13.9	9.2
6. Other physicians	7.7	9.4	2.8	7.2
7. Self or lay referrals (friends, relatives, neighbors)	11.5		2.8	4.6
8. Other Western Carolina Center Staff	5.8	4.7	2.8	4.6
9. University Medical Centers	7.7	1.6	2.8	3.9
10. Gaston-Lincoln Project	1.9	3.1	5.6	3.3
11. Other agencies or professionals		1.6	8.3	2.6
				N = 154

Children: Age, Sex, Race, "Intelligence," and Microcephaly:

The 154 infants evaluated by WCIP in 2½ years are equally divided by sex, with 77 males and 77 females. Most reported series have a preponderance of males. The population has been 138 white and 16 (10.4%) black. In 1974 nonwhite population of the Western Region was 12.5%. (Comparative references of this sort throughout the report are based on *N.C. Vital Statistics, 1974*.) The mean age of the infants at admission was 22.5 months (SD 10.6) and the median age was 23.7 months. Twenty-eight infants (18.2%) were less than 12 months of age at admission.

The infants were equally divided among the six categories of intellectual functioning (see Table 2): Normal 15.6%; borderline 16.2%; mild mental retardation 16.2%, moderate 16.2%, severe 18.2%, and profound retardation 16.2%. Two recent admissions to the program with cerebral palsy were not assigned intelligence quotients because of the difficulty in testing young infants with motor handicaps.

Twenty percent (30) of the total infants were microcephalic. Two were considered to be suffering primary (congenital, inherited microcephaly) and 28 from secondary microcephaly. (Mongoloids were excluded from this category for statistical purposes.) Twenty-five of these children were in the severe-to-profound range of mental

retardation. One child whose head circumference was below the third percentile had a normal developmental quotient (see Table 2).

TABLE 2

Degrees of Mental Retardation	Developmental Quotients	Number of Infants
Normal	85 & above	24
Borderline	84 -69	25
Mild	68 - 54	25
Moderate	54 - 35	25
Severe	34 - 20	28
Profound	19 & below	25
		N = 152

Cerebral Palsy

Sixty-five (42%) of the 154 cases had some degree of motor dysfunction (cerebral palsy). (See Table 3.) Most were judged to be moderately or severely involved.

TABLE 3

Categories of Motor Dysfunction	Number of cases
Ataxia	2
Hypotonia	8
Choreoathetosis	9
Dystonia	0
Rigidity	1
Tremors	2
Spasticity	43
Total	65

TABLE 4

MOTOR DYSFUNCTION

Degree of Motor Dysfunction	Level of Intelligence		
	Normal to mildly retarded	Moderate	Severe & Profound
None	53 (72%)	18 (72%)	16 (30%)
Mild	6 (8%)	1 (4%)	5 (9%)
Moderate	13 (18%)	5 (20%)	8 (15%)
Severe	2 (3%)	1 (4%)	24 (45%)
	N = 74	N = 25	N = 53

Of those children functioning intellectually within the normal to moderately retarded range, less than one-third had some motor dysfunction; of those functioning in the severely to profoundly retarded range, more than two-thirds had associated motor dysfunction. (See Table 4.) The severity of the motor dysfunction correlated roughly with the degree of intellectual impairment.

Twenty of the 30 cases of microcephaly had motor dysfunction; 85% of these were severely to profoundly retarded.

Of the 65 infants with motor dysfunction, approximately twice as many exhibited spasticity as the five other categories combined (Table 3).

TABLE 5

Location of Motor Dysfunction	Number of cases	(N=65)
Quadriplegia	42	(64%) **
Diplegic	16	(24%) *
Hemiplegic	5	(7.8%)
Paraplegic	1	
Triplegic	1	

* 3 of the infants with diplegia also had a hemiplegia.

** Includes all 9 choreoathetoids.

Two-thirds of the infants with motor dysfunction were diagnosed quadriplegic (See Table 5). This is to be expected because quadriplegics are identified very early in life. Less than 10 percent were hemiplegic. In other series of children with cerebral palsy, about one-third were hemiplegic (Woods, Crothers, Paine series, cited in Menkes, 1974). This condition is usually detectable during the second year of life. We cannot account for the low number of hemiplegics in our series. It should be noted, however, that there are two state-supported orthopedic hospitals in the Western area of North Carolina, and the hemiplegic children may present a primary orthopedic problem and consequently be referred to these services.

Sensory Impairments and Seizure Disorders

Of the 154 children evaluated in the Infants' Program, one-fifth were diagnosed as having impairments of the special senses. The most prevalent impairment was blindness or other visual handicap. A small number of infants had hearing handicaps or deafness.

Of the 31 children with impairment of the special senses, half had associated cranial anomalies, such as microcephaly (11 of the 16), hydranencephaly, hydrocephaly, or severe frontal bossing. Mental retardation, predominantly severe or profound, was present in all but four of these children.

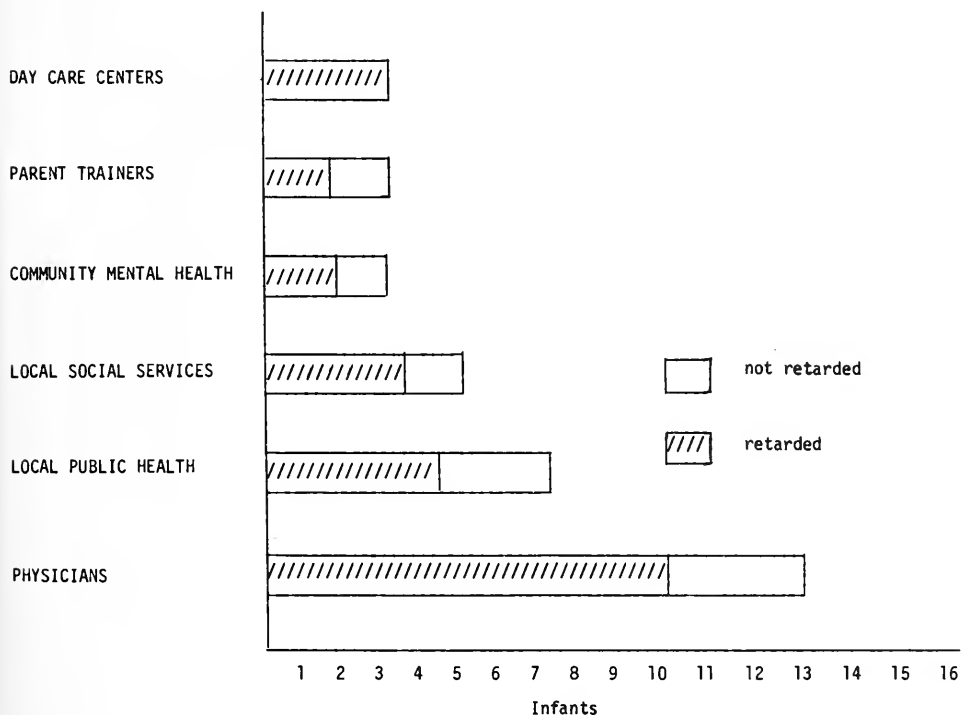
Motor dysfunction, nearly always spasticity, was present in two-thirds of the group.

One-fifth of the children followed in the Infants' Program had seizure disorders: 60% major motor seizures, 10% minor motor seizures, 27% mixed seizures. Only one child had typical petit mal seizures. Two-thirds had motor dysfunction. Three-fourths of those with seizures were severely or profoundly retarded.

Young Infants

In reviewing the charts of the 36 infants who had been 12 months of age or younger when first seen by the Infants' Program, the authors' initial opinion was that the more severely involved infants would be recognized and referred earlier. However, in actuality almost two-fifths of the group were found not to be mentally retarded. When this small series is broken down by referral source, it is apparent that physicians are referring the greatest proportion of delayed infants. (See Figure 1). Thirteen of the 36 were referred by physicians; ten of these were retarded and two of the three others had major medical problems.

FIGURE 1
REFERRALS OF YOUNG INFANTS



Three of the seven infants referred by local Departments of Public Health were not mentally retarded but had other medical problems causing them to test delayed on the Denver Developmental Screening Test. Two of the five young infants referred by County Departments of Social Services were not retarded.

Causes of Mental Retardation

In our series, as in others, the largest etiologic diagnostic category is unknown prenatal influence. Nearly a third of the infants were so diagnosed. The second largest category (12%) was perinatal hypoxia. Only those infants whose birth records documented definite fetal distress, prolonged resuscitation after birth, or severe respiratory distress in the neonatal period were so diagnosed. Low birthweight term infants and those with other associated anomalies were excluded from this category.

Eleven percent had chromosomal abnormalities. All but one of these had Down's Syndrome. Other known genetic diseases included one case of neurofibromatosis and one of Werdnig-Hoffmann Syndrome.

Prematurity was the primary diagnosis of 15 (9.7%) of the infants and a secondary diagnosis of seven; 3.9% were retarded because of prenatal cerebral infections, and 3.2% following postnatal cerebral infection.

Four infants (2.6%) had hydranencephaly (one unilateral porencephaly); three of these had ventriculoperitoneal shunt surgery; only two infants had primary hydrocephalus and two secondary hydrocephalus, following meningitis. Three infants (2%) were coded as retarded on a cultural-familial basis, when parents or other siblings were retarded and no organic diagnosis could be made. See Table 6.

TABLE 6

Primary Etiologic		
Infections and Intoxications	9	5.8%
Trauma or Physical Agent	22	14.3%
Metabolism or Nutrition	2	1.3%
Gross Brain Disease (Postnatal)	1	0.6%
Unknown Prenatal Influence	58	37.8%
Chromosomal Abnormality	19	12.3%
Gestational Disorders	16	10.4%
Following Psychiatric Disorder	1	0.6%
Environmental Influences	2	1.3%
Other Conditions	24	15.6%
	<hr/> 154	<hr/> 100%

Birthweight and Order

Birthweights of 127 of the 154 infants evaluated by WCIP were available. The mean birthweight was 6.01 pounds with premature-by-weight infants (those weighing 5.5 pounds or less at birth) comprising 36.1% of the group, more than four times the 8.62% premature rate for the 32 western counties of North Carolina in 1974. Slightly over 17% of WCIP infants weighed less than four pounds at birth. Thus, in this, as in most studies, prematurity is importantly associated with infant mental delay and handicap, directly or indirectly.

Of 139 WCIP infants with the information available, the mean birth order of the involved child was 2.27 (SD 2.22) and the median birth order was 1.68.

Family and Parent Characteristics

The mean monthly family income after taxes (i.e., net income) for the 122 families on whom we have such information is \$486.24 (SD \$246.43). This net income corresponds roughly to a gross or total family income of \$632, slightly below the mean income of families in our service area (Smith, 1972). For the 75 sets of parents who have been exposed to home-training for longer than four months, the fathers average completion of 10.9 years of education (SD 2.5) and the mothers 11.0 years (SD 1.9).

Based on home visits by Infants' Program social workers, 41.2% of the 148 family home environments evaluated were judged normal, 31.7% culturally deprived, 6.8% affectively (emotionally) depriving, 10.1% as showing significant emotional strain (usually marital conflict), and 10.1% of homes to show a combination of cultural and emotional problems. Relatively few infants were given primary environmental or cultural etiologic diagnoses (see "Causes of Mental Retardation" section).

Of clients, 72.7% were being reared by both natural parents, and 25.3% by the mother alone, or, in half of the latter group, by the mother plus grandparents or aunts.

Only 2.6% of client infants were being reared by one natural parent and one step-parent, equally divided between stepfathers and stepmothers. Two percent of the infants were being reared by grandparents or aunts; 2.7% by adoptive parents; and 4.7% were being reared by foster parents. Of those being reared by foster parents, only one-third (2 children) had been in more than one foster home.

TABLE 7

Termination	Cases	Percentage
(1) "Graduated"	13	26.5
(2) Referred to Infants' Program for consultation only	7	14.3
(3) Normal, did not need further services	7	14.3
(4) Died	5	10.2
(5) Moved Away	5	10.2
(6) Transferred to another program	4	8.2
(7) Chose against Home Training at outset	3	6.1
(8) Did not need further Infants' Program services	3	6.1
(9) Parents did not carry out programs with infant	1	2.0
(10) Chose against "Home Training" later	1	2.0
Totals	49	99.9%

Drop-Outs and Terminations

Forty-nine children and families who were evaluated at least once had ceased receiving WCIP services before January 1, 1975 (see table 7). The largest group of these children, 13 (26.5%), had become too old for ("graduated from") the program. The rest had left for a variety of reasons: some were evaluated for consultation only, some were judged essentially normal and not needing further services, and some had families who moved out of the service area.

Several families transferred from WCIP to another program, usually one closer to home. A few families rejected home training services at the outset (only one family rejected such services after beginning them) and received evaluation and short-term residential services only. Parents and staff agreed, prior to normal termination, that three infants did not need further WCIP services. In one case home training services were terminated because the parent did not carry out program recommendations in the home, though the family was assisted in obtaining a day center placement and consultation on the child continued to be given this day center.

Five infants had died, all but one of whom were severely or profoundly damaged, multi-handicapped infants and died of expected causes. One toddler, moderately-to-severely retarded due to unknown prenatal cause, aspirated half a hot dog in his home and asphyxiated.

Follow-Up Services

Twenty-five percent of children entered general or special developmental day programs before or shortly after termination; 17% were felt not to need further services at termination. An equal number had already begun periodic professional treatment and follow-up at termination (physical therapy for the largest subgroup; speech therapy or orthopedic treatment for several children; neurologic or nursing follow-up for individual children). It was unknown whether 7.7% of terminated children, most of whom had moved away, were receiving follow-up services, though referrals had been made in most cases. A profoundly multihandicapped group, 7.7% of all terminated children, were in group residential placement and an additional 5.8% were applying for residential placement. A similar number of parents were members of "parent training" groups. Two children (4.8%) were still receiving periodic respite (short-term residential) care from Western Carolina Center.

Summary

During the 2½ years prior to July, 1975, WCIP has developed and tested a home-centered system of delivery of comprehensive interdisciplinary programs and services for developmentally delayed and handicapped infants and toddlers living in 25 of the western 32 counties of North Carolina. In this system parents are the teachers of their children, and carry out individualized programs with them, guided by regular visits from a community or WCIP "home-trainer." Quarterly multidisciplinary team evaluations are carried out at the Center, goals set, and prescriptive programs written. The program's active home training caseload at the end of this period is 91 of the total 154 children evaluated, and 13 children are being worked with in a day program. Infants' Program goals, objectives, costs, and benefits have been briefly discussed.

A total of 154 children have been evaluated at least once by the program in 2½ years. These children have been described in terms of age, sex, birth order and weight, race, physical, and mental characteristics and handicaps, etiologic diagnosis, referral sources, reasons for terminating WCIP services, and services received subsequently. Correlations have been indicated.

Parents of client children and home situations have been described in terms of economic, emotional, cultural, and educational status. Other papers in this issue characterize the programs and rationales: physical therapy plus team and home-trainer functioning (Carter); the Infants' Day Program (Vonderweidt); cognitive intervention

and changes in client children over time, in relation to child, family, and home-trainer characteristics (Dunst & Brassell, Brassell).

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NOTICE TO CONTRIBUTORS

Manuscripts and editorial comments submitted for publication should be mailed to:

Drs. G. Tolley and T. Curtis
Editors-in-Chief
N.C. Journal of Mental Health
Dorothea Dix Hospital, Station B
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Manuscripts should be submitted in triplicate, double spaced, and total no more than 15 typewritten pages. The format of headings, tables, figures, citations, references, and other details should follow the style described in the *Publication Manual of the American Psychological Association*, available from the Association at 1200 Seventeenth Street, N.W., Washington, D.C. 20036. Tabular material, drawings and charts must be limited, due to publication costs, and should be submitted on separate sheets.

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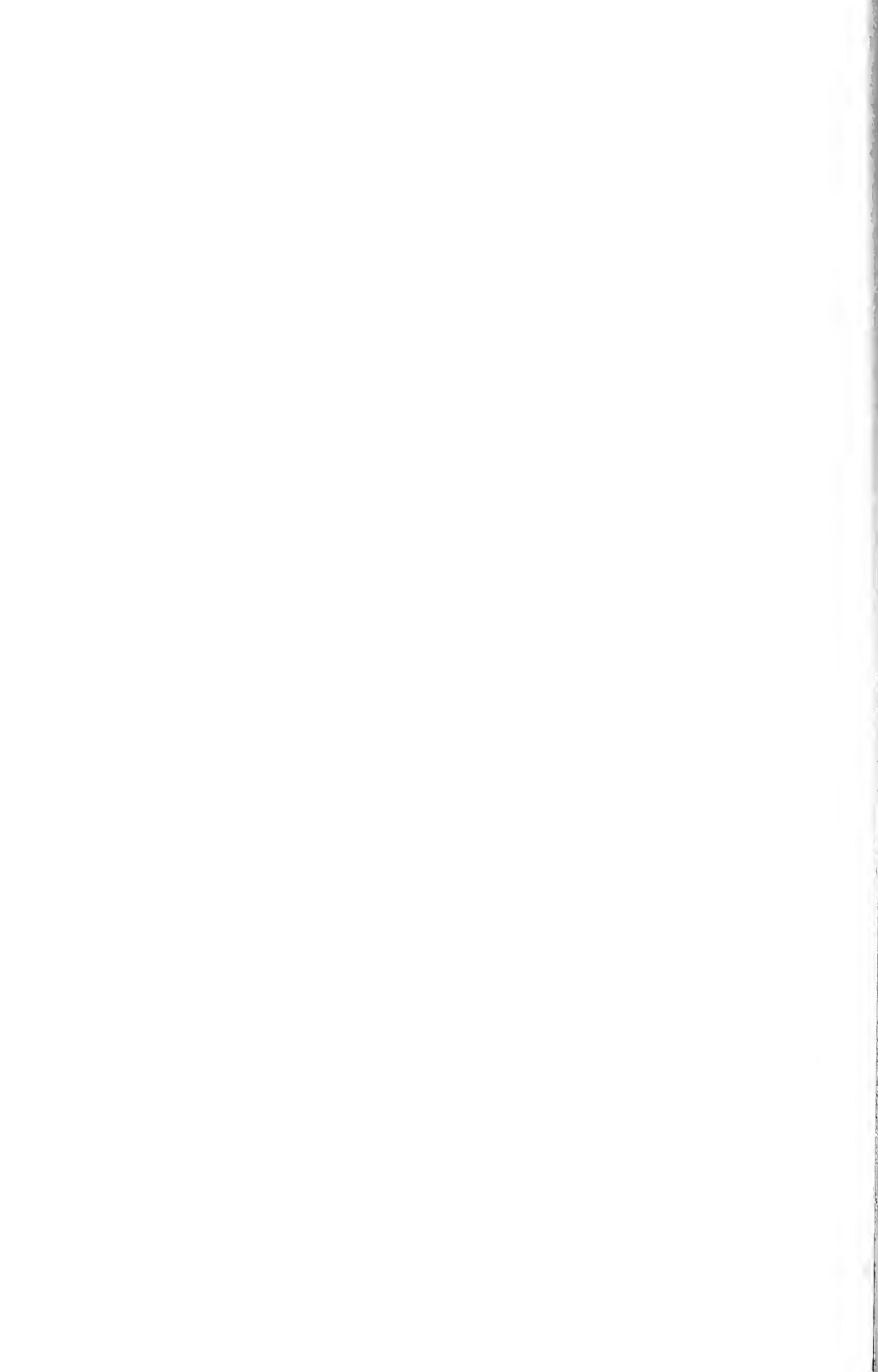
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INTRODUCTION

CONFERENCE ON PATIENT RIGHTS AND RESEARCH IN MENTAL HEALTH

The Fifth Annual Meeting of the North Carolina Division of Mental Health Research was convened on October 20, 1975, at Murdoch Center in Butner, North Carolina.

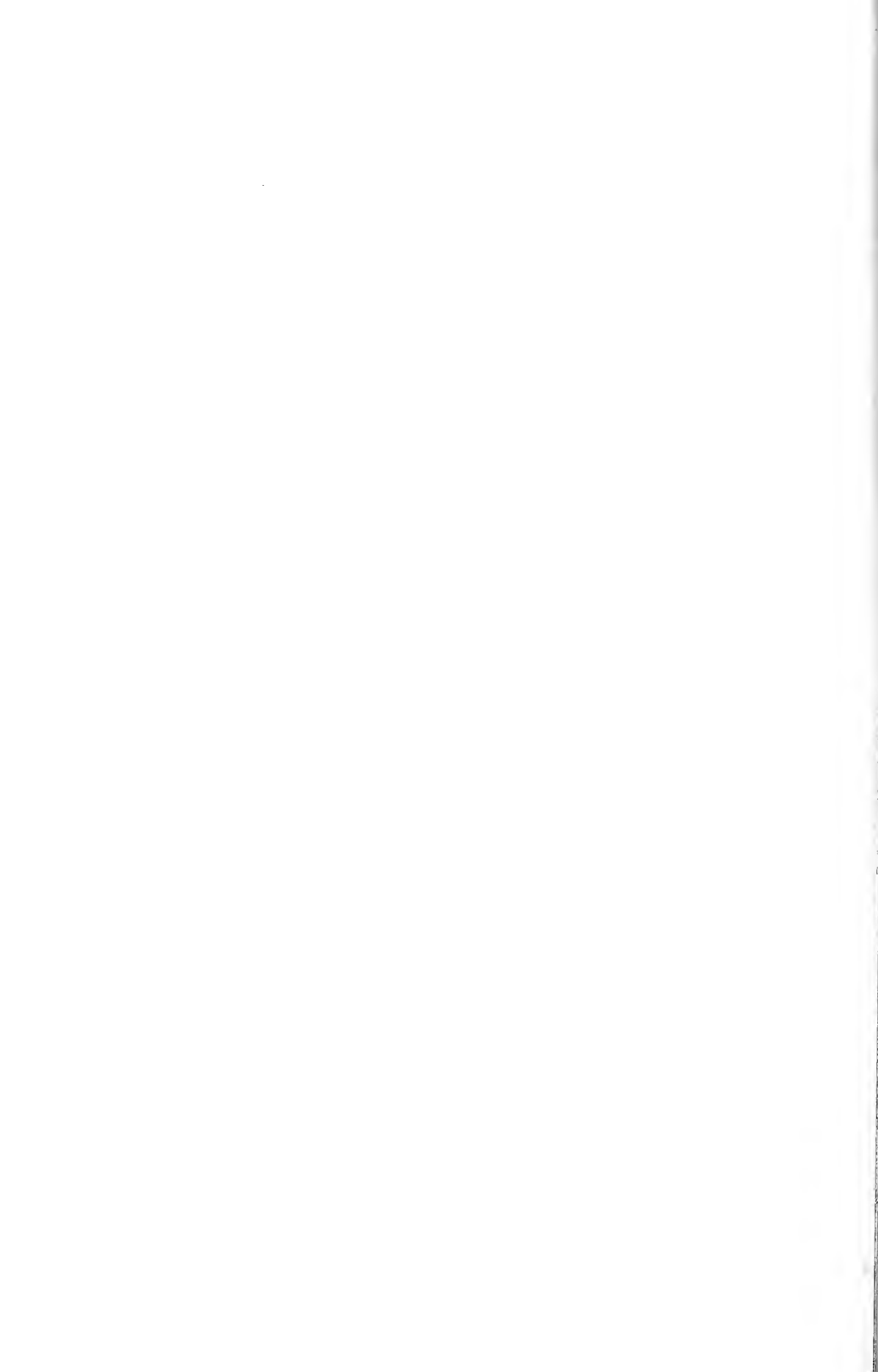
The theme for this meeting was Patient Rights and Research in Mental Health. The morning was devoted to presentations by invited speakers. Four topics covered were: The Role of HEW and the National Commission in the protection of human subjects, North Carolina Patients' Rights Legislation, the consumer's role in participation in Mental Health Research, and the researcher's view of Federal guidelines for the protection of human subjects.

The afternoon sessions were devoted to small group discussions on the implementation of the protection of human subjects. Several months before the meeting questions were solicited on a variety of topics from Mental Health professionals across the State. These questions were the basis of the discussions. At the end of the group discussions, each discussion leader presented a summary for the group.

Because of their excellent quality and the current public interest in patient rights, the presentations are published in this issue of the *Journal*.

Special thanks are due to Dr. J.F. Elliott, M.D., Director of Murdoch Center and Mr. Emery Miller, Director, Division of Special Supportive Services, for their hospitality in providing the facilities for this Conference.

Conference Organizers:	William Eichman, Ph.D.
	Ronald Oppenheim, Ph.D.
	Stephen Schroeder, Ph.D.
	Peter Witt, M.D.



THE PROTECTION OF HUMAN SUBJECTS IN BEHAVIORAL RESEARCH*

Barbara Mishkin, M.A.

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research*

History of HEW Activity in the Protection of Human Subjects of Behavioral Research

In 1965, the National Advisory Health Council passed a resolution regarding Public Health Service support of clinical research and investigations (Public Health Service, 1966). In order to protect the rights and welfare of the individuals involved, it suggested institutional review of the methods used to secure informed consent, and of the risks and potential *medical* benefits of the investigation. Note that while the benefits were labeled *medical*, the research and investigations were labeled — somewhat ambiguously — “clinical”. The resolution was adopted and amplified by the Surgeon General the following year, along with a memo of clarification extending its applicability to investigations involving the behavioral and social sciences (Public Health Service, 1966).

Five years later, when DHEW published its Institutional Guide to Policy on Protection of Human Subjects (DHEW, 1971), explicit reference was made to protecting human subjects from psychological and sociological harms, as well as physical ones. By way of explanation, the guide listed the following possible psychological or social injuries: “subjection to deceit, public embarrassment, and humiliation,” as well as “varying degrees of discomfort, harassment, invasion of privacy, or . . . a threat to the subject’s dignity through the imposition of demeaning or dehumanizing conditions.” The guide noted that: “In general, those projects which involve risk of physical or psychological injury require prior written consent,” although provisions were made for modification of consent requirements when full compliance “would surely invalidate objectives of considerable immediate importance. . . .”

An important addition to the discussion in the HEW manual is the caution to pay particular attention to case and statutory law which may define the rights of the subject with respect to consent and invasion of privacy.

*Views presented in this paper are those of the author. No endorsement by the commission has been given or should be inferred.

The Right to Privacy: Legal Benchmarks

When we speak of protecting a person’s privacy, we are saying that the individual has a right to consent, or refuse to consent, to another’s access to his or her person. Recent court cases suggest that the protection of the person now seems to encompass an individual’s mind as well as body. To some extent, in other words, psychological integrity is emerging as a legally protectable part of an individual.

One of the first—and most eloquent—statements regarding the subject was written by Justice Brandeis in 1928:

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. . . . They sought to protect Americans in their beliefs,

their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be left alone - the most comprehensive of rights and the right most valued by civilized man. (*Olmsstead v. United States*, 1928).

That statement was cited by the majority in two recent decisions of the Supreme Court. One was a case involving the right of unmarried women to have access to contraceptives (*Eisenstadt v. Baird*, 1972), and the other was the case concerning women's rights with respect to abortion (*Roe v. Wade*, 1973).

Several lower courts, in the last few years, have considered the question of protecting thoughts, emotions, and sensations, with interesting—and important—results. A U.S. circuit court expressed concern, in 1973, regarding the right to be free from “impermissible tinkering with mental processes” (*Mackey v. Procunier*, 1973). (That case involved the use of aversive conditioning in a program at Vacaville Prison, in California.) That same year, in a case involving psychosurgery (*Kaimowitz v Department of Mental Health*, 1973), a Michigan court held:

In the hierarchy of values, it is more important to protect one's mental processes than to protect even the privacy of the marital bed.

It observed, in addition, that:

The integrity of the individual must be protected from invasion into his body and personality not voluntarily agreed to. Consent is not an idle or symbolic act; it is a fundamental requirement for the protection of the individual's integrity.

By way of emphasis, the court further concluded:

There is no privacy more deserving of constitutional protection than that of one's mind....Intrusion into one's intellect...is an intrusion into one's constitutionally protected right of privacy. If one is not protected in his thoughts, behavior, personality, and identity, then the right of privacy becomes meaningless.

One other case—also decided in 1973—deserves mention, here: that is *Merriken v. Cressman*, which involved a program to identify and treat potential drug abusers in a Junior High School in Norristown, Pennsylvania (*Merriken v. Cressman*, 1973). It is not clear from the opinion the extent to which those planning the program perceived it to be research. However, the court noted as a finding of fact that it was a “drug prevention approach as contrasted with drug rehabilitation efforts...designed to aid the local school district in identifying potential drug abusers, prepare the necessary interventions...remediate the problems and finally, evaluate the results.”

Those of you who are familiar with the case will remember that the plan was to distribute questionnaires to the students asking them to answer questions about their own emotional states as well as their family interactions. In addition, they were asked to identify other students in the class whose behavior struck them as unusual or inappropriate. (The students were left to their own devices to define “unusual” and “inappropriate” in this context.) Briefly, the rest of the program involved identifying potential drug abusers on the basis of the responses to the questionnaires, and then applying remedial intervention (in the form of guidance and group therapy sessions) which would be directed by teachers with no formal qualifications or training other than a “short crash course.”

The court found that questions raised involved primarily the invasion of privacy without consent. The investigators did not plan to ask the students whether or not they wished to participate; and they sent the parents only a letter which disclosed comparatively little about the program, and advised that unless written objections were received by a certain date, consent would be assumed. A confounding problem was that even if parents or their children had refused to participate (that is, refused to fill in the questionnaire), those children still could be assigned to the remedial part of the program on the basis of observations of other students that their behavior or language was "unusual." In other words, not only was consent not sought; withholding consent would have made little difference. Finally, it was planned to distribute data and evaluations derived from the questionnaires to teachers, superintendents, athletic coaches, PTA officers, and school board members.

An unresolved question is the extent to which the program would have been considered unconstitutional even without the compulsory remediation, and without the dissemination of data and conclusions to persons other than those directly involved in designing the questionnaire. Suppose, for example, this had been simply an investigation to determine whether such a questionnaire could provide reliable information on which to base valid predictions about a student's potential involvement with drugs. I think that certain holdings of the court would still obtain:

1. The full disclosure of the purposes and methods is required;
2. That active consent of the parents should be obtained; and
3. That consent of the students might also be necessary.

Let me quote what the court said on this point:

The Law does not abound with cases, or expert treatises on the problem of personality testing and confidentiality, and the problems of informed consent. However, in a recent Federal Bar Journal article...there is some insight into the problem...[and he quotes]:

Informed consent for personality testing should be comparable to the informed consent ideally obtained by a physician prior to the performance of surgery (Sheerer and Roston, 1971).

Recent Congressional Activity

Hearings were held in 1973 and 1974 by Senators Ervin and Kennedy, on subjects ranging from behavior modification (in prisons, V.A. hospitals, and public schools) to psychosurgery, privacy, access to records of public school children, and, of course, experimentation with human subjects. A number of reports and bills were produced, from which the following pertinent legislation emerged:

1. The National Research Act (July 12, 1974) which created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research [P.L. 93-348];
2. The Buckley amendment, Privacy Rights of Parents and Students, (August 21, 1974) which governs access to records maintained by educational institutions and agencies [§438 of the General Education Provisions Act, Title IV of P.L. 90-247]; and
3. The Privacy Act (December 31, 1974) which declares: "The Congress finds that...the right to privacy is a personal and fundamental right protected by the Constitution of the United States." [P.L. 93-579]

In addition, the Subcommittee on Constitutional Rights of the Senate Judiciary Committee published a report concerning the nature and extent of behavioral research in this country, and the constitutional questions which are raised by that research (Subcommittee on Constitutional Rights, 1974). In the introduction, Senator Ervin wrote:

Two basic considerations have motivated our investigation: first, the concern that the rights of human subjects of behavioral research are sufficiently protected by adequate guidelines and review structures; and second the larger question of whether the federal government has any business participating in programs that may alter the substance of individual freedom.

Senator Ervin noted that a number of government agencies fund, participate in, or otherwise sanction behavioral research without adequate review procedures or standards for the participation of human subjects; and he recommended that the report of his subcommittee be forwarded to the newly created National Commission for the Protection of Human Subjects, in the hope that appropriate and effective review procedures would be developed.

Let me describe, more fully, the creation, the duties and the activities of the Commission.

Events Leading to the Creation of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research

A few special problems led to the legislative activity which culminated in the creation of the Commission. It was learned that patients with syphilis had gone untreated in Tuskegee for research purposes for almost 40 years despite the availability of effective treatment. Although the study had been initiated prior to the development of review procedures by the Department of Health, Education, and Welfare, it did continue long after these procedures were in full force.

Early in 1973, the Supreme Court handed down a decision regarding women's rights with respect to abortion (*Roe v. Wade*). The force of this decision was to stimulate concern that aborted fetuses would be used as experimental subjects in ways which would offend the public conscience and indeed occasional reports of research activity gave credence to this concern.

Articles concerning psychosurgery brought to public attention the use of surgical techniques to treat a variety of emotional problems ranging from aggression in prisoners to hyperactivity in children. Civil riots, followed by articles on the surgical control of aggressive behavior, heightened public concern (Mark, Sweet and Ervin, 1967; Mark and Ervin, 1970), as did reports that such procedures had been used on several prisoners in Vacaville, California.

The Senate Health Subcommittee, chaired by Senator Kennedy, held a series of hearings on issues related to human experimentation, including psychosurgery, the Tuskegee Study, the unapproved use of approved drugs (Depo-Provera, DES), and research involving prisoners (Subcommittee on Health, 1973). The Subcommittee already had before it several related bills including one introduced by Senator Beall to prohibit Federal funding of psychosurgery for a period of two years pending a study by the Secretary, DHEW, of the safety and efficacy of these procedures (S.J. Res. 86, 1973). Similar activity had been generated in the House of Representatives (Subcommittee on Public Health and Environment, 1974).

Almost unnoticed at the time was activity within the Department of Health, Education, and Welfare, specifically within the National Institutes of Health, to provide additional protection for children, the fetus, the abortus, prisoners, and the institutionalized mentally disabled participating as subjects of biomedical and behavioral research (DHEW, 1973). Concurrently, the Department undertook to translate existing policies governing research with human subjects into Federal regulations applicable to all research, development and related activities conducted or supported by DHEW (DHEW, 1974). This strengthened the force of the guidelines, and specified their applicability both to intramural research and to agencies in the Department which are not part of the Public Health Service.

Problems which were unresolved by existing policies (now, regulations) can be summarized as follows: first, they accept proxy consent by legal representatives on behalf of a subject who cannot give his or her own consent to participate in research—although there is no legal basis for volunteering someone else as an experimental subject. Second, they do not address the questions surrounding the quality of consent which can be given in an institutional setting, such as a prison or mental hospital, where personal autonomy and individual integrity are greatly diminished. (I shall discuss these issues more fully, later.)

There is a jurisdictional problem, as well. The DHEW regulations are applicable only to projects conducted or supported by the Department of Health, Education, and Welfare. Many Federal agencies, however, either conduct or support research involving human subjects. These include the Department of Defense, the Department of Justice, the Veterans Administration, the Department of Transportation, the Department of Agriculture, NASA, the AEC, and even HUD. Many of these adopt the DHEW policies in whole or in part; but the procedures used to protect human subjects in Departments outside DHEW are not uniform.

Finally, the DHEW regulations do not define "research, development and related activities" except to say that they differ from "accepted practice." Distinctions are difficult to draw with respect to innovative surgery such as heart transplantation or psychosurgery, for example, or with respect to innovative rehabilitation programs for prisoners.

Congress was aware of the effort at DHEW to develop additional protection for special subject groups, but when Congressional hearings ended, the drafting at DHEW was still in progress. In addition, because the public was demonstrably concerned, Congress decided a national commission should examine the issues and involve the public in the difficult decisions which were required. Thus, a bill emerged which contained among its provisions portions of many of the other bills related to human experimentation. It was signed into law (P.L. 93-348) by the President on July 12, 1974, creating the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

The Commission's Mandate

The Commission is composed of eleven members with diverse backgrounds and experience. During its two-year life, the Commission is required to:

- Identify the basic ethical principles which should underlie the conduct of biomedical and behavioral research involving human subjects;
- Develop, and recommend to the Secretary, guidelines to ensure that research is conducted in accordance with such principles;

- Consider the boundaries between research and the routine practice of medicine, the role of risk-benefit criteria in evaluating research, guidelines for the selection of subjects for research, the nature and definition of informed consent in various settings, and mechanisms for evaluating and monitoring the performance of local Institutional Review Boards;
- Identify the requirements for informed consent to participation in research by children, prisoners, and the institutionalized mentally infirm;
- Consider the appropriateness of applying the principles and guidelines identified above to the delivery of health services under programs supported or conducted by the Secretary;
- Determine the need for a mechanism to protect subjects of research which is not under the jurisdiction of the Secretary, DHEW, and recommend such mechanisms to the Congress;
- under the jurisdiction of the Secretary, DHEW, and recommend such mechanisms to the Congress;
- Investigate the nature and extent of research involving the living human fetus, and, within 4 months of empanelment, report to the Secretary, DHEW, the circumstances (if any) under which research may be conducted or supported;
- Investigate the recent use of psychosurgery, determine the appropriateness of its use, and recommend policies defining the circumstance (if any) under which its use may be appropriate;
- Undertake a "Special Study" of the ethical, social and legal implications of new advances in biomedical and behavioral research; and
- Recommend to Congress the functions and authority of the National Advisory Council for the Protection of Human Subjects to be established July 1, 1976.

Fulfilling Its Mandate

In May, 1975, the Commission fulfilled its first mandate by forwarding to the Secretary, DHEW, a comprehensive report on the use of the living human fetus in biomedical research, with recommendations concerning the conditions under which such research should be conducted or supported (National Commission, 1975).

In fulfilling the remaining legislative charges, the Commission will hold hearings on such topics as psychosurgery, and the involvement of children, prisoners, and the mentally disabled in research activities. A Minority Conference is being planned by the Urban Coalition, under Commission auspices, to solicit active participation of minority groups in bringing their special concerns to the attention of the Commission. A major study is under development to gather empirical data on the activities and effectiveness of Institutional Review Boards operating under DHEW regulations; and investigations concerning the extent of psychosurgery as well as its safety and efficacy are under way.

The Commission has conducted several site visits: one, to the Fernald State School for the Retarded and the Eunice Kennedy Shriver Research Center in Waltham, Massachusetts, another to the State Prison of Southern Michigan at Jackson, and a third to Saint Elizabeth's Hospital in Washington, D.C. The purpose of the visits is to learn first-hand about the prevailing conditions in such institutions, the constraints which the residents may be under, the problems of administration and care, and the reasons for doing research in such settings. In each instance, we have talked with the residents, the staff, the research personnel, and members of the committees who review research protocols.

To supplement what can be learned on site visits, we have contracted with a number of experts to prepare papers for the Commission on such subjects as: the boundaries between biomedical and behavioral research and the routine and accepted practice of medicine, the role of assessment of risk/benefit criteria, the nature and definition of informed consent in various research settings, the freedom and competence of children, prisoners, and the institutionalized mentally infirm to make choices regarding participation in research, the use of deception in behavioral research, and a number of other issues.

Issues Before the Commission which are Pertinent to Behavioral Research

The issues which the Commission must consider which are pertinent to this symposium, include the problems surrounding informed consent by (or on behalf of) children and the mentally disabled, the question of who benefits from certain therapeutic research procedures, and the problem of distinguishing the boundary between research and accepted practice in the field of mental health.

A. The Problems Surrounding Informed Consent

The Nuremberg Code would seem to preclude the participation of children and the incompetent in nonbeneficial research. The first principle of that code states explicitly:

The voluntary consent of the human subject is absolutely essential. This means that the person involved should have the legal capacity to give consent (*U.S. v. Brandt*, 1949).

The apparent clarity of this statement, however, is clouded by the written statements of two individuals who participated in the drafting of the Code. Leo Alexander, whose first draft of principles formed the basis of the Code, has written that the original draft contained provisions for consent by next of kin on behalf of mentally incompetent patients, but that the judges omitted those provisions in the final version "probably because they did not apply in the specific cases under trial" (Alexander, 1970). Similarly, Andrew Ivy, chief medical consultant to the War Crimes Trials, wrote (in the same year the Code was published) that:

The ethical principles involved in the use of the mentally incompetent are the same as for mentally competent persons. The only difference involves the matter of consent. Since mental cases are likened to children in an ethical and legal sense, the consent of the guardian is required (Ivy, 1948).

The record does not show whether the judges at Nuremberg overruled their medical consultants on this matter or whether, as Alexander suggests, they simply followed judicial custom by limiting their opinion to the facts of the case at bar.

The Declaration of Helsinki, published by the World Medical Association in 1964 (in Beecher, 1970), provides that for nontherapeutic research, "if (the subject) is legally incompetent the consent of the legal guardian should be secured." The acceptance of this Code by the American Society for Clinical Investigation, the American College of Physicians, the American College of Surgeons, and particularly the American Medical Association resulted in the general acceptance of proxy consent for nontherapeutic research throughout this country (Beecher, 1970).

The 1971 Institutional Guide to DHEW Policy for the Protection of Human Subjects required the consent of a subject "or his authorized representative." It did not define "authorized representative," but cautioned that:

The review committee should consider the validity of consent by next of kin, legal guardians, or by other qualified third parties representative of the subject's interests. In such instances, careful consideration should be given by the committee not only to whether these third parties can be presumed to have the necessary depth of interest and concern with the subject's rights and welfare, but also to whether these third parties will be legally authorized to expose the subjects to the risks involved (DHEW, 1971).

DHEW regulations published May 30, 1974 provide that consent may be obtained from an individual's "legally authorized representative" defined as "an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to such subject's participation in the particular activity or procedure" (DHEW, 1974). Strictly construed, this provision would permit proxy consent only in those jurisdictions which specifically authorize a third party to consent for another's participation in research. In fact, the Department notes that:

Whereas it is clear by law that consent of a parent or legal guardian is valid for established and generally accepted therapeutic procedures, performed on a child or an incompetent adult, it is far from clear that it is adequate for research procedures. In practice parental or guardian consent generally has been accepted as adequate for therapeutic research, although the issue has not been definitively resolved in the courts. When research might expose a subject to risk without defined therapeutic benefit or other positive effect on that subject's well-being, parental or guardian consent appears to be insufficient (DHEW, 1973).

The Department suggested therefore that parental or guardian consent be supplemented by the judgement of a consent committee, as well as the assent of the child or incompetent. Thus:

Although children might not have the capacity to consent on their own to participate in research activities, they must be given the opportunity (so far as they are able) to refuse to participate. The traditional requirement of parental consent for medical procedures is intended to be protective rather than coercive. Thus, while it was held to be unlawful to proceed merely with the consent of the child, but without consent of the parent or legal guardian, the reverse should also hold (DHEW, 1973).

Similar requirements were proposed for the institutionalized mentally disabled, and strict limitations were proposed for research involving institutionalized children.

It should be noted that HEW defined the Institutionalized Mentally Infirm (later changed to "Disabled") to include:

"individuals who are mentally ill, mentally retarded, emotionally disturbed, or senile, regardless of their legal status or basis of institutionalization (DHEW, 1973).

The language of the first draft was adopted in the legislation creating the Commission. Critics have questioned the scope of this definition. Some have said it is too broad; others have said it is too narrow. Some believe only those who have been judged incompetent by a court should have special consideration. Others believe that all mentally disabled individuals (whether or not they are institutionalized) should have special protection. This is one issue the Commission must resolve, at the same time that

it must decide how to solve the problems surrounding informed consent by (or on behalf of) these individuals.

B. Special Considerations Regarding the Institutionalized

The institutionalized mentally disabled may be handicapped both by their disabilities, and by the effects of institutionalization. For the most part, patients in institutions have little opportunity to make decisions for themselves even regarding trivial matters, much less regarding medical treatment (be it standard or experimental therapy). It has been reported that approximately 26 out of every 10,000 Americans are in a public mental hospital; and four-fifths of these patients are under involuntary commitment (Kittrie, 1971). In some states, individuals who commit themselves voluntarily are considered civilly incompetent nevertheless by virtue of being institutionalized. Laws vary as to the extent to which the superintendent of an institution may give proxy consent for a patient to participate in research activities, and the situation is changing rapidly, but so long as such authority exists, it merits concern, especially when procedures may be applied which in fact benefit the institution's staff more than (or rather than) the patient.

Problems of a different sort arise when institutions ask parents, family, or legal guardians to consent on behalf of their patients. Care of the chronically or seriously ill can be emotionally as well as financially exhausting. Thus, the possibility of placing a relative or ward in an institution for care, or the opportunity for free care, may be an inducement difficult to resist. Further difficulties emerge after an individual has been institutionalized for a period of time, and the family is relieved of daily care and concern. The best interests of the patient may become less clear to those responsible for his or her care as time and distance intervene.

In fact, on the site visit to the Fernald State School and the Shriver Research Center, the Commission heard from Dr. Murry Sidman that still another factor may influence parental consent. That is the fear that the institutionalized child or relative may be sufficiently improved by participating in the research program that he or she will be returned home. Dr. Sidman believes that this fear may prevent the research team from obtaining consent from parents - especially those who have little contact with the institution. On the other hand, he suggested that those parents who visit their children often and who are eager for them to improve may consent to almost anything in the hope that it will help. The Commission would be interested in learning of any studies which have attempted to correlate parental consent (or refusal) with frequency of visits to the institution.

If the patients themselves are asked to consent to their participation in a research project, different problems arise. In addition to their scant opportunity to make decisions and their generally diminished sense of personal integrity, institutionalized individuals may feel obliged to cooperate with the staff even if they would prefer not to. This is especially true for the mentally ill, whose hospitalization is not usually expected to be permanent, and whose discharge may depend (or at least seem to the patient to depend) on conveying an appearance of cooperation or reasonableness. It matters little whether the staff perceives participation in a research activity to be a good sign; if the patient believes the staff will take that view, the effect is the same. When proposed research is considered therapeutic, an institutionalized individual may be under more pressure to participate insofar as the possibility exists that the anticipated benefit may relieve the mental illness and thus increase the likelihood that the patient will be released.

Three recent court opinions have addressed these issues. In one (*Kaimowitz v. Department of Mental Health*, 1973), the court reviewed considerable testimony regarding the loss of autonomy which occurs in an institution, and held that informed consent cannot be obtained from an involuntarily detained mental patient because "he is particularly vulnerable as a result of his mental condition, the deprivation stemming from involuntary confinement, and the effects of the phenomenon of 'institutionalization'". The issue in *Kaimowitz* was the validity of a patient's consent for psychosurgery which, the court noted, is a dangerous and irreversible procedure. Some regard the statements in the decision concerning the diminished capacity of an institutionalized individual to consent to be applicable beyond the context of hazardous experiments.

The primary issue in the second case (*Wyatt v. Stickney*) was the right of institutionalized mentally disabled individuals to treatment. Nevertheless, in setting forth minimal requirements for the humane treatment of the institutionalized mentally disabled, the court provided that patients may not be subjected to experimental research or even to unusual or hazardous treatment procedures without their express and informed consent, if they are able to give consent, and the consent of their guardians and next of kin, after opportunities for consultation with independent specialists and legal counsel. Further, such procedures are to be instituted only with the prior approval of an interdisciplinary Human Rights Committee. In affirming that part of the decision, the U.S. Circuit Court observed that "that conditions of confinement do not invade the constitutional rights of those confined" (*Wyatt v. Aderholt*, 1974).

The third case parallels the second except that it applies to children at the Willowbrook School and rests on an argument of protection from harm. Although it, too, is primarily a right-to-treatment case, the consent decree which was entered in January, 1975, absolutely forbids medical experimentation and, in addition, requires the creation of several review and supervisory committees to implement the standards and procedures enumerated in the consent decree (*N.Y. State Association for Retarded Children v. Carey*, 1975).

General rules must be found which on the one hand permit further understanding of psychological disabilities, and at the same time both protect the vulnerable and the dependent and preserve their dignity and their right to self-determination to the extent they are able to participate in decision-making.

C. The Question of Benefit

Questions may also be raised regarding the beneficiaries of an investigation. For example, when residents of a school for the retarded received experimental injections of Depo-provera, the consent form which was signed by parents or guardians reads:

This drug is to be injected every three months for the purposes of preventing menstruation, thereby making resident more comfortable to lessen nursing care. A second purpose is that of preventing pregnancy in the event of exposure (Arlington Hospital and School, 1973).

One might well question whether the staff or the residents received the primary benefit from this program. Similar questions can be raised regarding proposals to modify the behavior of disruptive individuals. The question of who, in fact, benefits from a given program must be evaluated with care.

D. The Relationship and the Boundaries Between Research and Practice

We were faced with several interesting questions at Fernald School, which are pertinent to all such institutions:

1. The staff was young, dedicated, and top-notch. Dr. Moser, the Superintendent, said this was a direct result of research funds. To what extent should this be considered in our deliberations?
2. How ethical is it to begin treatment programs with research funds, when it is likely (or even certain) they will be cut off after a year or so?
3. At what point do the data from behavioral research become sufficiently convincing that new therapeutic techniques are no longer considered experimental?

Dr. Sidman's techniques for training the retarded seem to have been very successful. The staff at Fernald, for the most part, endorses the token economy method, and is often enthusiastic in their support. From what we saw, there seemed to be good reason for their enthusiasm. Dr. Sidman's projects still undergo review by the Institutional Review Board at the Shriver Research Center; although he contends that what he is doing is education, not research. This is a good example of what the Commission calls the "Boundaries" question: what is the boundary between research and accepted practice? How can we tell research from therapy, from rehabilitation, or even from education? How can we define research so that the investigators, and those who must review their work, will know what projects require review? In other words, what will fall under the "applicability" provisions of the regulations which eventually will be drafted?

The Commission must grapple with this question, in order that its recommendations (and the regulations which will be derived from them) will apply to everything that should be considered research, without being needlessly broad and encompassing too much.

Summary

In summary, the Commission is faced with many unresolved questions which impinge upon the conduct of behavioral research. During the next year, we shall draw on many resources to assist in formulating recommendations which will be supportive of necessary and important research activities, but at the same time protect individuals who are asked to participate in those activities. Our meetings are open to the public, and we welcome letters and position statements from individuals and professional organizations. We hope that the result of our efforts will assist and protect both the research community and its human subjects.

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**A RESEARCHER'S POINT OF VIEW ON CURRENT FEDERAL REGULATIONS
ON
RESEARCH IN MENTAL HEALTH**

**David Zeaman, Ph.D.
Department of Psychology
University of Connecticut**

Regulations protecting human subjects in psychological research can be made so restrictive as to preclude federal funding in the area of mental disability. A number of spokesmen in psychology have expressed this concern. For example, last year Dr. John Clausen, representing the American Academy on Mental Retardation, sent a memorandum to the membership of that group on the proposed Federal Guidelines for the Protection of Human Subjects. Dr. Clausen said that the academy was in full agreement with the principle that human subjects who participate in medical research should be adequately protected, but not so zealously protected as to render research nonfeasible. Specifically, Dr. Clausen said:

"To us who are engaged in research in Mental Retardation, the most disturbing part is the Guidelines' indiscriminative definition of risk. We do not understand that such activities as administering intelligence tests, determining memory functions, recording motor activities, or monitoring heart rate, or electroencephalographing in anyway be considered harmful."

Clausen also argued that the consent regulations were too restrictive. He said the requirement that both parents should give written consent to participation in research for institutionalized retarded subjects would at best make psychological research exceedingly cumbersome and would, in many cases, make it impossible. To obtain such written consent, it is likely to make parents suspect endangering risks exist. It is suggested that the requirement for written consent be confined to situations where physical risk is involved.

Clausen was not alone in his concern. Robert Sears, President of the Society for Research in Child Development, wrote in the Newsletter of that Society in the Summer of '74:

"On November 16, 1973 in Federal Register, NIH published a document suggesting a large number of new and highly restricted controls on researchers. Some of these involved the total exclusion of certain types of children from any research whatever. Such excluded groups were composed of children with only one parent for example and children who had been placed in a custodial institution. The statement denied that this publication was a formal step toward rulemaking, but it was evidently a trial balloon to see how far the anti-science forces could go in destroying the possibility of research with children."

After SRCD's pressure on Congressmen and NIH officials, Sears wrote:

"NIH's trial balloon has not been shot down but it has received a good deal of unwelcomed visibility. The office of the director acknowledges that some 450 protests have been received. The whole matter of exclusionary classes of children will be examined. It is expected that additional rules will be made in

the next couple of months. However, unless there is continued monitoring of the process, the possibility of severely restrictive controls remains open."

Sears went on to point out that none of NIH's coterie of rulemakers appeared to be a practicing scientist or health professional. In listening to Barbara Mishkin, I noted that, of the 11 members of the National Commission, there were no behavioral researchers (two physiological psychologists, no behavioral ones).

The main cause of much of the furor in massive rulemaking has been a very small number of medical studies. Sears said:

"NIH submitted no evidence publicly that there have been abuses of children in psychological or other behavioral research, but the bills before Congress lump biomedical and behavioral research together to provide a single package for restriction and control."

This was in the summer '74 that Sears reviewed NIH's rulemaking with alarm and called for moderation and common sense. A full year later in the Summer of '75, Sears again reported in the SRCD Newsletter that federal regulations for psychological research were still a problem. Referring again to the November '73 Federal Register, Sears said:

"It suggested many impractical and debilitatingly restrictive rules. the governing council [that is the SRCD] along with hundreds of other individuals and organizations responded instantly with vigor and that balloon has been shot down temporarily."

It was not at all clear to me after reading all the Federal Registers I could find on the protection of human subjects what balloons had been shot down, what rules had the force of law, which were guidelines, and which were merely suggestions for further discussion. Since the November 16, 1973 Federal Register on NIH's "Protection of Human Subjects Policies and Procedures," I have been able to find two others on the same topic: one dated May 30, 1974 entitled, "Protection of Human Subjects," and a later one, dated August 23, 1974 entitled, "Protection of Human Subjects Proposed Policy." While it was clear that the '73 Federal Register was intended to be an acknowledged first draft for discussion purposes, it was not at all clear whether the May and August issues of '74 represented descriptions of final, or at least current, regulations on protection of human subjects. The fact that the August '74 bulletin was entitled, "Proposed Policy," suggested a nonfinal form, but to date it is the only thing that I have had to go on and it is far from clear. The writers of the proposed rules appear to have been borrowed from the IRS with specialties in obscurity.

There are three major questions of interest to Mental Health researchers. These key questions concern the definition of risk, lumping of biomedical and behavioral research, and the definition of informed consent. After reading and rereading the three Federal Registers I had on these issues, it was not clear to me what the answers to these questions were. For example, the August '74 Federal Register says that the newest regulations "redefine 'subject at risk' so as to exclude any activity which does not increase the ordinary risks of daily life."

This language is vague, perhaps justifiably so. It could possibly be interpreted to include almost all behavioral research as not risky. At present, I suspect that institutional review committees are given responsibility for making the judgment of risk with quite vague guidelines. The August '74 regulations do give the Secretary of HEW

the authority "for determination in advance as to whether a particular Federal program or an investigational method or procedure may place subjects at risk." Apparently some sort of catalogue of risky or non-risky procedures might be issued at a later time. In the meantime, review committees, I presume, make their own judgments.

On the question of informed consent of institutionalized mental disabled subjects, that is, the psychotic retarded, geriatric, emotionally disturbed, and so on, the November '73 rules were severely restrictive, but the August '74 rules were somewhat more relaxed in giving more power of judgment to consent committees and also to the secretary of HEW:

"Where a particular activity involves negligible risks to the subjects, an applicant may request the secretary to modify or waive the consent requirements. If the secretary finds that the risks are indeed negligible and other controls are provided, he may grant the request in whole or in part."

Although a great deal of alarm has been sounded on the restrictions and vagueness of federal regulations on human subjects, we might ask how are things going in practice? In this respect, I have only informal reports to make based on my nonsystematic, casual observations: I ask around a lot. Consider my own case. For the last couple of decades, I have been doing psychological research with a population of institutionalized retardates. My research is supported by federal grant money and it is well monitored for the ethical use of human subjects. There are at present no less than six committees that review my research. At the university level, we have a Departmental Review Committee and also a University-Wide Committee that reviews ethics of my grant proposal. Those are the first two committees. The institution at which my subjects reside, the Mansfield Training School, has a Human Rights Committee designed to meet federal review regulations with humane treatment of resident retardates in research, training, and demonstration projects. The state of Connecticut has a Central Committee made up of delegates from each of the human rights committees of all the institutions within the state. Both of these committees review my research. That makes four committees. The granting agencies, NIMH and NICHD, which fund my grant, have a Research Review Committee that considers not only scientific merit but also ethical issues involved in all grants. I have sat on such committees myself for eight years and they have always considered ethical aspects very heavily. Finally, the final approval of research grant money rests with the various councils of NIH which also strongly consider ethical use of human subjects.

Six committees are a lot, comprising several dozen people at least. But none has raised any ethical objection to my research despite the fact that the early issues of the Federal Register on the protection of human subjects specifically exclude from research involving risk children "detained by court order in a residential facility." None of the committees judged my specific research projects to involve risk, and reasonably so. My subjects participate voluntarily in game-like situations which provide tests of learning, memory, attention and transfer. Incidentally, there is a seventh source of ethical review of my research and everyone else's too in this area. The journal editors publishing research in this area review the ethical characteristics of the research and they are a very sticky lot.

From talking to colleagues on campus and other universities, I have not found any who have had their behavioral research terminated or made impossible by stringent application of new federal regulations whatever these turn out to be. I have heard

anxieties expressed from researchers in the areas of infant perception or in the psychology of retardation that they might be denied access to their subjects or be required to get written consent from both parents of their subjects to meet federal regulations, which could be a crippling requirement. But I have yet to meet anyone who has suffered in this respect. Some may exist but they have not yelled loudly.

I recognize that this may be a temporary state of affairs growing out of the confusion and vagueness about federal regulations. I do not believe that even many institutional and federal review committees have a good understanding of the regulations that they are supposed to administer. For example, I went to the Human Rights Review Committees both in the University and Training School (there are four such committees), and I asked them for copies of all the regulations governing their judgments. They all had copies of the three Federal Registers that I have referred to: the November '73, the May '74, and the August '74, but nothing later. I read, however, in the October 17th issue, which was the last issue of *Science*, an article by one of their editors, Barbara Culliton, saying that there was now a new set of regulations on the protection of human subjects in the August 8th issue of the Federal Register, which I presumed was 1975. Although these have been out for two months, these regulations have not trickled down to the level of the institutional review committees or to the level of the investigator. I have been unable to find anyone who has them.

Not only are these new regulations widely unread, they are wildly controversial among the few who have read them, according to Barbara Culliton. In her article entitled, "Fetal Research, HEW Rules Depart from Commission's Recommendations," a most revealing account is given of the recent history of the federal rulemaking on protection of human subjects and research. In 1973, an NIH committee drew up a set of tentative regulations published in the '73 Federal Register. HEW received a mountain of comment from the scientific and general community on these rules and was in the process of revising them when Congress appointed the National Committee for the Protection of Human Subjects in Biomedical and Behavioral Research. Although this Commission had no authority to write regulations, it had the authority to write recommendations which the HEW Secretary must either comply with or explain why not in public. The new ethics committee did not complete any of its recommendations until May of this year. So HEW has been reluctant to print any final set of regulations until the commission's recommendations were available.

The general confusion on what regulations were in force was understood in this context. What is worse, it turns out that Ethics Committee and HEW are apparently in disagreement on the issue of research with fetuses, with the Commission saying no to the research with non-viable fetuses and HEW rulemakers saying yes. The issue was still to be resolved and is complicated further by a bill now up before Congress by Kennedy, Javits and Schweiber that would dissolve the present Commission and create a new one with broader powers, new membership and a permanent status. What this will do for the conflict between HEW staffers and the judgment of the ethics commission, old and new, is at present anyone's guess.

From the researcher's point of view, I have mixed feelings about this confused frenzy of rulemaking at the federal level. At the present time probably because of the confusion decision-making is less by rule than by local review committees. These seem to be working adequately, I infer from the absence of any notorious cries of outrage from the research community, but maybe we have been just lucky so far. I can imagine certain circumstances in which for example my own research could be terminated by a few

politicized members of a review committee. One of my major subject variables is intelligence and I know that there is a small but vocal group of academics, American Lyenkoists, who believe that intelligence tests are instruments of racism and that anyone who gives credence to a concept of relatively fixed intelligence is guilty of fostering genocide. The presence of such a heavily politicized person on a review committee could cause great mischief.

The antidote to the possibility of abuses of local autonomy of ethics review committees is a set of highly explicit rules. These, of course, have their dangers and drawbacks as well. One common tendency of rulemakers is to be overly restrictive and conservative. Better to kill 100 research studies than to permit one abusive research privilege.

I think one of the best statements on the freedom of inquiry was written this year as an editorial in *Science* by DeWitt Stetten, Jr., who is deputy director for Science, NIH. He points out that the Constitution explicitly forbids abridgement of speech and press. "It imposes no comparable constraint to abridging freedom to learn, to teach, or to inquire, yet these may be construed to be implicit freedoms and indeed seem to be of comparable quality." Further, all of these freedoms are in fact abridged from time to time, subject to the test of a real and present danger. In the absence of such demonstrable danger, the accepted position is jealously to guard the constitutionally guaranteed freedoms, both those expressed and those that are implied. I don't think that Mr. Stetten was the author of rules that were put out by HEW or the Commission.

I think that the concept of real and present danger has not guided all of the samples of rulemaking that I have seen in respect to the ethics of behavioral studies. The risks of behavioral studies are most commonly boredom. At worst some embarrassment, pique or deception. Nothing constituting real or present danger, nothing requiring elaborate sets of rules in multiple committees for review. I was appalled at some of the language of the early Federal Registers. They spoke of adopting the language of the Nuremberg Code, not once but several times. Somehow I did not feel that the trials of the Nazi war criminals had much to do with the evaluation of the ethics of my research. I wondered whether we convened a grand jury for a parking ticket.

To wrap up, my general conclusions are: (1) that from the researcher's point of view that the Federal regulations on research and mental health in wide areas are simply in too confused a state currently to permit careful evaluation, (2) that no widespread infringement of behavioral research or freedom of inquiry has yet taken place, and (3) that behavioral research is likely to be over-regulated in as much as it does not represent a clear and present danger.

A PARENT/CONSUMER VIEW OF RESEARCH IN MENTAL RETARDATION

H. Rutherford Turnbull, III
Institute of Government
University of North Carolina at Chapel Hill

I. INTRODUCTION

I want to discuss the relationship between the researcher and the consumer and their respective roles and responsibilities in establishing mechanisms and policies for the conduct of research in mental retardation. In particular, I have a single proposal to advance—that consumers become far more directly involved in setting research priorities than they are now, and that, to this end, investigators actively seek to increase informed consumer participation in setting and funding research priorities.

II. THE RESEARCH CRISIS

There is a research crisis in mental retardation. Research has been relatively short-changed in the sense that total funds for mental retardation activities have been not only limited but also diverted from research to developmental costs, those associated with assisting the retarded in their social and intellectual development.

Moreover, basic and applied research seems to be the object of a current wave of anti-intellectualism. It suffers from the belief that research does more harm than good and thus should be limited and carefully monitored. This strange notion ignores that counterproductivity of many facets of our life. It also ignores the weight of the evidence that it is rare to find a investigator who values his data and inquiries more than his subject's health and well-being. True, there have been instances of grievous harm to human subjects at the hands of irresponsible investigators, but they are rare.

The reaction to the abuses tends to be an over-reaction. A moratorium on research is hardly an intelligent answer. Nor are the merits of DHEW regulations beyond question. They may do the very thing AAMD seeks to avoid: they may jeopardize research involving mentally retarded persons by an overburdensome set of procedural and other restrictions (AAMD "Guidelines on Research Involving Mentally Retarded Persons," June, 1974). They surely result in a bureaucratic overload, with the concomitant real risk that paperwork, not research, will consume the investigator's time and energy, and that bureaucratic aggrandizement will unnecessarily hamper the investigator. Mandated to regulate, agencies seek reasons to regulate and ways to regulate, all in order to justify their existence and expansion.

Mental retardation research is in crisis for other reasons, mostly collateral to the value and intrusiveness of the research itself. The anti-abortion movement threatens to become a roadblock to fetal research. Right-to-treatment litigation and legislation have limited behavioral research. A new civil rights battle for the overdue establishment of retarded persons' legal rights threatens to divert our attention from the crucial importance of research to the very people we seek to help. Political ambitions are whetted and advanced by focusing on the uncommon abuses in human experimentation. The federal government's policy of fiscal restraint drains away the richest research funds; and that very same government, in an attempt to achieve highly visible results and thereby wide popular support, has launched massive armadas against cancer and heart disease, necessarily preventing funds from being spent on mental retardation research.

These collateral currents inexorably and unhappily feed into the main current of reducing funds for basic research, requiring research to be justifiable by immediate results, and placing unbalanced faith in improving the future for the retarded by concentrating on developmental amelioration. Joined together, the collateral and main currents reach flood-stage proportions, preventing us from concentrating on the need for research, setting research priorities, and advancing research.

To begin to counter the crisis in mental retardation research, all of us, but especially consumers, need to recognize the immeasurable value of basic research, much of which (as in the case of PKU or amniocentesis screening) yields high returns for low costs. We also need to recognize that scientists feel and are threatened by the crisis; ironically, they need consumer help, now, more than ever. We must realize that restrictions on research may prevent the retarded from benefitting from as well as serving in research. Indeed, if the social contract theory has a contemporary meaning for retarded persons, it is because it offers them, with adequate procedural safeguards, the chance to fulfill their side of the contract by participating in research; our side of the social contract is our agreement to safeguard their legal and human rights. We also must recognize that procedural restrictions on and limited funding of research may deter talented people from entering the mental retardation field, to the ultimate detriment of the retarded. We must not fail to see that research on institutionalized retarded persons (as required by JCAH accreditation standards) should be carried on if only because there is far more continuity than discontinuity between normal and retarded persons and that the institutional setting provides us with degrees of experimental control and longitudinal research that are lacking elsewhere and can benefit both the normal and retarded. We must agree that it is desirable to subject the investigator to a rule of accountability and to the inquiry of a broader community of interest than other investigators, but we should recognize that, just as we ought not to curtail surgery because some physicians cut too deeply or too quickly, we ought not to curtail research because it sometimes is abusive. To limit our visions by unduly curtailing research will consign us to endure too long and unnecessarily our present inadequate state of knowledge about the prevention and amelioration of mental retardation; it will require us to forego developing alternatives to the damaged baby, the impaired life, and to electric shock, drugged acquiescence, and physical restraint.

III. HISTORY AND CRITICISM OF REVIEW-OF-RESEARCH MOVEMENT

The requirement that research be reviewed is not new. We decided long ago that research should be reviewed by government (through Congressional and regulatory agency action), by peers of the investigators (through review committees of universities or other sponsoring institutions, the National Academy of Science, the National Institutes of Health, and Human Rights Review and Protection Boards), and by consumers (through Human Rights Review and Protection Boards and consumer interest group political activity).

If the purposes of peer or governmental review are to be the positive ones of legitimizing research, encouraging research not now undertaken, and striking the balance between the investigator and society, not just the negative ones of minimizing risk to the subjects and devising review protocols that attempt to balance professionalism and professional interests, on the one hand, with moral implications of the research, on the other, then it is not sufficient to leave to scientists alone the

opportunity and power to advance these purposes; they alone are not the best persons qualified to do these jobs.

The advantage of heavy consumer representation in peer or governmental review is, among others, that scientists may thereby be encouraged to seek to do experiments they would not otherwise do but for the legitimizing presence of consumers on the review boards. In my experience, it is not rare for a parent of a mentally disabled child to be more willing than mental retardation professionals to attempt to habilitate his child by controversial or intrusive treatment techniques. Perhaps this same daring to risk will be a characteristic of consumers on review boards.

It is not an easy matter for me, as a parent of a severely mentally handicapped boy, to assure myself or others that I would subject my son to research in etiology or treatment of mental retardation. I have many issues to consider: What is the risk-benefit ratio for Jay? Will my decision be an informed one? Will it be rational and find acceptance among society, as frequently represented by a court? Do I, or does society, have the authority to require Jay's participation in an experiment or in a medical or behavioral procedure that is possibly not of any direct benefit to Jay and may even be contrary to his expressed will or consent (his capacity to consent is not the same as his expressed will)? May I overrule his wishes? May he overrule mine, assuming he is asked (assuming his capacity is not the same as assuming he is asked and expresses a will that is not based on the type of capacity to consent we would require for legally effective consent)? If he were legally capable, what would he agree to do—to participate, or not? Although I ask these questions of myself with respect to experiments on him while he lives, would I ask the same, or different ones, if the research is to be conducted post mortem? Will I allow his brain to be dissected after he dies, in the interest of research? Will I allow his behavior and capacities to be bio-medically or behaviorally altered, while he lives? Would I allow the research to be conducted on my non-handicapped daughter? On my wife? On myself? What is the nature of the contribution that Jay is most able to make to society? Is it as a subject in human research? Perhaps so. Perhaps that is his social contract. Perhaps not. I do not know the answers to these very difficult issues of ethics, these very real issues of the father-son relationship. I do know, however, that I believe that I, as a consumer, must be given an opportunity to systematically and regularly participate in reaching answers, partly through my participation in setting priorities for mental retardation research.

We are thus concerned about advancing the consumer's impact on the investigator because consumer involvement can (I do not promise it will) have new and positive effects on the scientist. There are still other reasons, moreover, why consumer participation in review of research, and thus in setting priorities in research, may likewise benefit the investigator.

IV. THE CONSUMER AS A TRANSLATOR

Recently, several highly placed and respected mental retardation professionals, recognizing the need for mental retardation research centers to disseminate their research achievements to their colleagues at other centers, to consumers, to resource-providers, and to potentially supportive interest groups, have made persuasive arguments for developing staff capacities to collate, interpret, translate and communicate the applications of research results to human needs in meaningful terms. To fail to do so, they assert, obscures their research accomplishments and diminishes their claims on national priorities. And, I, as a consumer who for a long time was baffled by

the unwillingness of mental retardation professionals working with my son to explain why they were doing what they were doing (the rationale for treatment procedures), join in the argument for a mechanism by which research can be made understandable, acceptable, and welcome by a consumer.

In considering the issue of translation of research, we must continually ask—What is the purpose of mental retardation research? If the purpose is what we purport, to ameliorate and prevent mental retardation, then it is mandatory that the findings of basic research be translated and disseminated to consumers and service-providers. If results find their way only into professional journals or remain inside isolated laboratories, then it can be argued that the particular research findings have not yet contributed to efforts to combat mental retardation. This situation occurs far too frequently. In the area of learning, sophisticated theoretical models are rarely translated into techniques and procedures which can be utilized by a special education teacher to enhance the learning potential of mentally retarded students. Curriculum development is often based on intuition or whim rather than the systematic findings of the scientist. There is a tremendous gap between theory and practice, a gap which is detrimental to both the scientist and consumer.

Where do parents of retarded individuals learn about information related to etiology, diagnosis and treatment? Most parents do not subscribe to the professional journals of the scientist or attend their professional meetings. Their sources of information are frightfully limited; however, they have tremendous responsibilities for providing 24-hour care and habitation of their family member. Unfortunately, the most widely used source of information for parents is probably popular magazines which are often only minimally accurate in their reports. Presently, many parents are cut-off from the information they desperately need.

What efforts are now being made by North Carolina mental retardation research centers to translate the fruits of the research to consumers, particularly parents and community-based professionals whose jobs are to assist the mentally handicapped? For example, are the research results at Western Carolina Center synthesized so as to be useable and then made available to community and consumer principals? Is the excellent work at Murdoch Center in overcoming self-injurious behavior made available to the other state centers and consumers and professionals in local or area mental health centers? Is the work of the distinguished psychology research team at the Child Development Institute, UNC-Chapel Hill, made available to the Department of Public Instruction for transmission to school psychologists and special educators in our state's public schools? These are but some of the questions we should ask about translation of research to and through the consumer.

There is an urgency for a translator of research, for a person to interpret the scientist's findings to the general public. Although all basic research does not and should not have the requirement for immediate application, much of what is presently known through the fruits of basic research could now be extremely beneficial if it were translated to consumers and service providers. The utilization of research would serve to increase and highlight the contribution of the scientist and the necessity for continued research efforts. This concept of the intermediary between the scientist and public must be promoted and adequately funded to encourage creative and talented mental retardation professionals to become involved in this activity. Strong consumer support for translation and interpretation might increase the probability for priority given to this function.

V. THE CONSUMER'S STAKE IN RESEARCH

Consumers have various interests that entitle them to participate not only in peer or governmental review and regulation but also in the setting of research priorities. Consumers are, of course, directly and indirectly affected by the research; they are its present or future beneficiaries. They also pay for the research through taxes and fees.

They can be a powerful lobbying force, one that can help elevate mental retardation to a higher priority among the various research-funding sources. Granting the fact that not every mental retardation research project can be funded, since resources are finite, consumers who participate in priority setting may find that the priorities are more acceptable to them; accordingly, they may express their satisfaction to funding sources. Given the gaps between the consumer, the funding sources and the investigators, an expression of consumer satisfaction is desirable as a potential bridge.

Consumer participation can help overcome the isolation of the scientific community from the general public and increase the dialogue between investigators, consumers, the general public, and resource providers; a result of extinguishing the relative isolation of these groups from each other may be an improved communication system that will produce additional mutual understanding and support, especially financial support of research activities.

Consumer participation in research priority setting is an affirmative action on the road to accountability; as such, it is to be contrasted to the present, largely negative consumer methods for achieving accountability—the withholding of consent, the review of research as part of the function of human protection boards, and resort to litigation.

Finally, consumer participation in setting mental retardation research priorities may lead to new priorities being set in all areas of scientific, bio-medical or behavioral research; a possible, indeed likely, result can be the emergence of mental retardation research claims that will challenge the highly favored cancer and heart disease research.

I anticipate that my suggestion for consumer participation in mental retardation research will produce a volley of objections from the scientists. They will argue that consumers are not scientists. This is an incorrect generalization. They will say that consumers will not understand research methods or goals or the potential uses of research. This incorrectly assumes that consumers are not able to learn or evidences the investigators' unwillingness or inability to teach. They will contend that consumers will unduly interfere by being too time-consuming or too inquisitive. This speaks to the nature of the mechanism for consumer participation but not to the value of their participation. They will maintain that consumers will object to or veto some proposed research activities. This is simply a way of saying that investigators do not trust consumer judgments, that they do not or cannot explain their research activities, or that the mechanism is faulty. They will rationalize their fears that consumers will be able to direct or dictate the direction and nature of research activities. This suggests the need for investigators to provide the consumer with options, speaks to the mechanism, and provokes the answer that the investigator at last fully comprehends the meaning of accountability.

Investigators, no less than other professionals, are reluctant to let their activities be supervised by other persons; they are, perhaps, more reluctant because they have been traditionally independent of and isolated from consumers. Yet it is precisely their

independence and isolation that may be one of the major causes of the research crisis in mental retardation. I have argued that point and why the consumer should be involved. I would now like to suggest how he might be involved.

VI. THE EXTENT AND NATURE OF CONSUMER PARTICIPATION IN RESEARCH PRIORITY SETTING

Presently, consumer participation in research priority setting is both limited and negative. On a national basis, for example, NARC's Research Advisory Committee is making some site visits to mental retardation research centers, but the impact of those visits is not yet determined. PCMR does not substantially involve itself in research priority setting. There is limited consumer participation on the National Advisory Council and in the deliberations of other resource providers. Participation through the requirements of informed consent or by membership on human rights protection groups is negative (the consumer may only withhold consent) and secondary (the research activity is conceived without his participation and presented to him for his reaction). Finally, consumer-sponsored litigation on the rights to treatment and consumer-supported legislation on patients' rights have restricted the professional instead of giving him guidance and sustenance.

It seems clear that a far more positive approach to consumer participation is required. To attempt to achieve this goal, we must be cautious about the mechanism or procedure.

It is apparent what the mechanism or procedure should not be. It should not be a device whereby the consumer can (to a greater extent than he already is able) effectively veto a research project. We do not create a positive approach by increasing our reliance on negative or veto procedures. The device should be representative of consumer organizations, and, to this end, officials of such organizations, or their designees, and should participate in setting research priorities. But the device should include the affected consumers themselves or representatives who are not officers, directors, employees, or designees of consumer organizations; the disabled persons themselves, as well as their parents, siblings, guardians, attorneys, clergymen, and friends should be given the opportunity to participate. Finally, the device should insure participation by a broad cross-section of affected consumers; it must guard against being the captive of a small number of interest groups.

The Association for Retarded Citizens, the Society for the Autistic, the Mental Health Association, the Easter Seals Society, the United Cerebral Palsy Association, the Association for Learning Disabled Children, Parents and Professionals for Handicapped Children, and a host of other consumer organizations in North Carolina, as well as professional groups such as the Council for Exceptional Children, the Office for Children, the Mental Health and Mental Retardation Divisions of the Department of Human Resources, and the Division for Exceptional Children of the Department of Public Instruction are, in my opinion, all consumers of research, and are all entitled to participate not only in reviewing and monitoring the research but also in helping to set the direction the research will take at our mental retardation centers and mental health hospitals, and in our public schools.

In a more positive vein, the mechanism should not only allow for but be designed to actively seek out the advice and counsel of consumers; some type of affirmative action procedure might be required to evidence that consumer participation has been actively sought.

It should enable the consumer to specify his research priorities; thus, it should offer him choices among research activities and an opportunity to propose additional priorities; it should not necessarily involve him in deciding if a particular research project is of higher priority than some other project; it should enable him to specify, as well, his priorities among research in various areas. Accordingly, the mechanism should require the consumer to specify whether he prefers research in behaviors to research in genetics, i.e., research in amelioration in preference to research in etiology, or whether he prefers research on certain types of retardation, such as Down's Syndrome in preference to microcephaly, i.e., research on one condition in preference to another.

Because of the unfortunately high incidence of retardation among the socio-economically disadvantaged, the mechanism should insure their participation. I can recall only a few times in my experience when the disadvantaged have been actively involved in citizen or professional activities. As much as we may dislike requirements of proportional representation or quotas in some areas of our activities, we may find that those safeguards will be appropriate.

The mechanism should require that mental retardation professionals from disciplines other than the investigator's should participate in priority setting, since they are, in one sense, consumers of the fruits of research activities.

The mechanism should require the investigator to interpret, translate, and communicate the applications of the anticipated research results to human needs. The device should institutionalize the proposals that the investigator demonstrate how his research will affect the consumer by potentially preventing or ameliorating mental retardation.

Finally, the mechanism should provide for critical and aggressive surveillance of the activities of federal, state, and private resource providers. It should enable the consumer to learn about, understand, and affect agency programs, budgets, criteria for funding research, decision-makers, decision-making processes, and whether or how the agency-funded research has been effective in preventing or ameliorating mental retardation.

What form should the mechanism or procedure take? Here, the options are numerous. Special consumer research-priority groups might be established as adjuncts to governmental bodies such as the State Departments of Human Resources and Public Instruction, within the consolidated University of North Carolina system, the North Carolina Developmental Disabilities Council (one of the few agencies with an almost pure form of consumer representation), the Commission on Children with Special Needs, and the Mental Health Study Commission, to name but a few state agencies whose work involves sponsoring, conducting or consuming research in mental retardation.

The federally assisted mental retardation research centers and university-affiliated facilities likewise can create adjunct or advisory consumer groups. This would be appropriate for the Child Development Center at the University of North Carolina at Chapel Hill.

Consumer and professional organizations such as NCARC, among the consumer groups, and CEC, among the professional groups, can create consumer task forces to assist in setting priorities for research.

Next year, this Division, in cooperation with federal, private, and university research agencies and funding sources, might sponsor a conference of national, regional or area

scope on mental retardation research. The conference would consist of a review of past, present, and future research goals, activities, funding, achievements, and disappointments. It would be for the benefit of consumers, who would be the majority of the participants, and it would be designed primarily to enable them to make inquiries of and suggestions to researchers and the research fund providers concerning research needs, goals, priorities, and funding.

North Carolina can show the way for the rest of the nation, and should.

VI. CONCLUSION

Consumers and investigators are mutually interdependent; indeed they are mutually indispensable. Yet their relationship is hardly a happy one. It is tainted by criticism, suspicion, and restrictions. It does not have to be this way. It can be, instead, far more profitable. Without incurring an inordinately negative reaction from investigators, I hope that I have been able to stimulate you to think about enhancing our relationship by identifying a goal—consumer participation in research priority setting, providing reasons for seeking the goal, and enumerating methods for achieving it. There are undoubtedly other ways to enhance our relationship, but I believe this way has the unique potential of forging a powerful consumer-professional alliance and of moving all of us more rapidly to the prevention and amelioration of mental retardation.

Thank you.

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DISCUSSION GROUP ON RIGHTS OF HUMAN SUBJECTS IN RESEARCH

**Billie F. Corder, Ed.D.
Dorothea Dix Hospital
Raleigh, North Carolina**

**John Vandenberg, Ph.D.
Department of Mental Health Services
Raleigh, North Carolina**

This summary of the group discussion represents notes taken during actual discussion and is an informal record of the informative interchange and thoughts about this topic by group members. In the informal discussion group, initial work centered around difficulties in establishing some of the basic definitions of critical terms in research with human subjects. For example, considering the interweaving of service and research functions in gathering all types of data, when is a client or patient legally defined as becoming a research subject? In general the group agreed that data is being gathered on human subjects under the following conditions: a.) when the data is being utilized, or functions being performed which are not aimed at specific therapeutic goals for the specific individual involved, and does not constitute part of a routine, on-going program or service monitoring system of the patient's treatment program, and/or b.) involves any treatment which is not part of generally accepted and standard medical or scientific procedures. When an accepted procedure or treatment is significantly modified, it may then become an experimental procedure (and the patient becomes a human subject).

Specific questions were raised within the group regarding "accepted and standard medical and scientific" practice and treatment. Ms. Barbara Mishkin, HEW representative, mentioned that aversion therapy has been brought to a halt in Connecticut on the grounds that it is legally "unproven and experimental." Some members were concerned about the status of legal use of token economy and behavior modification programs within this framework. In general, the group discussion focused on the critical importance of operating these programs within a "floor of minimum rights (adequate recreation, clothing, shelter, food, communication opportunities, etc.)" without which the patient is never deprived, with token economy and behavior modification rewards representing extensions of these basic necessities, rather than ever removing or limiting any of these *basic* necessities as a result of failure to respond to program goals. Another difficult area which the group explored was the confusion related to establishing the legally responsible party in obtaining permission for subject participation in research. Ms. Mishkin emphasized that laws vary widely from state to state in regard to such matters, giving as an example that a pregnant, underage mother might not be able to give permission for her child to be involved in research in certain states. Even when individual responsibility for legal consent is clear, other problems have been experienced according to Ms. Mishkin, who reported current California litigation in which parents of infant to five year old children were paid \$300, and fairly "intrusive" experimental procedures were utilized which had no specific benefit to the child. Undue inducement has been charged as rendering void the consent of these parents for their child's participation. Some of the vital issues involved in this case were reported as: a.) Can permission for intrusive techniques be given by proxy when these techniques do not benefit the individual involved? b.) If the benefit from the research is only to

society in general, and only of dubious or little value to the subject, must absolutely no risk or discomfort be experienced by the subject? c.) Would the placing of any research inducements into a trust fund for the child remove some of the objections? d.) Can inducements for research be permitted in studies for which only poor and underprivileged groups would be attracted or permit their children to participate?

Use and construction of consent forms was an issue around which some of the following questions were centered: How can the problem of bias be avoided when total disclosure of the experiment on the consent form would effect the results? Most group participants appeared to feel the necessity for accurate and fairly detailed descriptions of the techniques, purposes, and uses of the study on any consent forms used, and felt that research committees would give assistance in writing information which reasonably described techniques without giving more details than necessary for the study procedures. Ms. Mishkin stated that the typical standards utilized in deciding to reveal aspects of a study's procedure in consent forms were, "What information would make a difference to a reasonable man (in deciding whether or not to participate in a study)?" Participants agreed, however, that specificity to the greatest degree possible within that definition should be maintained in the subject consent forms.

It was also pointed out to the group that signing of a consent form does not necessarily mean that a subject cannot later change his mind about participation or about withdrawing his permission for data to be utilized in the study; the subject does not necessarily give up his right to change his mind or to withdraw his consent at a later date.

The use of video tapes was discussed and critical issues outlined were: a.) It is necessary to secure permission for subjects to film or record them AT ALL TIMES, whether or not they are involved in experimental procedures or studies. b.) This permission and consent must be quite specific as to the use of the recorded material, the groups to whom the material is to be shown, and the purposes for which it is shown. Further questions regarding the extent of the descriptions of use of material on consent forms for video tape were again referred to the standard, "What would a reasonable man need to know to make a decision about his participation?"

Anxieties over the ambiguity of many definitions in this area may have accounted for some discussion of the issue of individual experimenter liability in research in state facilities. The importance of following official research committee guidelines, procedures and channels for approval and evaluation of research was emphasized. Ms. Mishkin reported on some current studies at the National Institute of Health, where the possibility of developing some form of "no-fault research accident insurance" was being explored.

In closing the group discussion, it was reiterated that appropriate avenues for dealing with specific, individual problems, questions, and approval of research planning techniques existed within individual, formal Research Committees found in most state facilities. State employees of agencies without specific Research Committees can obtain guidance and help by contacting the Regional Review Committee through the offices of Dr. Vandenberg or Dr. Zarzar, Albermarle Building, Raleigh.

DISCUSSION GROUP ON ADVOCACY AND PATIENT RIGHTS ISSUES

Ben Sauber
Dorothea Dix Hospital
Raleigh, N.C.

The Workshop on Human Rights was conducted by Ben Sauber, Director of the Advocate Program which supplies advocates for residents at Dorothea Dix and John Umstead Hospitals and for clients of mental health services in the South Central Region; Larry King, Director of Advocates at Western Carolina Center; and Dr. Peter Witt, Chief of Research for the North Central Division of Mental Health Services.

Following a brief report by each of the three panelists describing their own roles in the field of advocating for the rights of patients, the rest of the session was devoted to answering questions posed by particular members of the workshop.

It was most interesting, I thought, that the majority of questions were in relation to "why" was so much being made of patient's rights, and *how* were the advocates of patient's rights operating."

It seemed as though there was a great deal of feeling that staff personnel themselves should and could protect the rights of their patients. Most, if not all, of the participants recognized that that was an ideal that history tells us is not always practiced. The Advocates recognize the professional's role as an advocate for their clients and that an advocate program is primarily designed to take care of the client's interest in those cases where staff cannot help the patient, refuses to help the patient, or when staff abrogates the right of a patient.

Of the many questions in regard to "how" the Advocates operate, it was apparent that a great deal of concern was in regard to whether the Advocates were going to primarily be adversaries of staff. There was big difference in the manner of expressing a response to this point but I believe that I can summarize the viewpoint of the panel by saying that they saw advocacy as being the protector of rights for the consumers with the realization of all concerned that if the necessity arises, an advocate will become an adversary to any party that has in fact abrogated the civil rights or human dignity of a resident and refuses to correct that abrogation.

Another oft repeated statements was, "How about the rights of staff?" It is most interesting to me that so many people in the humane delivery services field feel that in allowing their clients to have and to exercise their personal rights is to deny the service provider his "right" to dictate to the consumer in what he calls "the best interest of the consumer." We spent considerable time discussing this issue from two major points. We spent considerable time discussing this issue from two major points. The law does provide for the protection of the rights of staff personnel in relationship to the civil and human rights of their clients. By establishing a more clearcut understanding of the intent of the "patient's rights" laws, the service provider, if he follows the procedures outlined by the law, is free from many of the abrogations hitherto thrust upon him. Following those procedures means more paper work (documentation) but a more careful and complete documentation of the provider's dealings with the client will protect the provider from possible legal action and it will also establish a more clear and cogent means of communication between all of the various disciplines that provide service to each individual client.

Another way of looking at the rights of mental health and mental retardation consumers is, "Suppose the client was you or yours"

**INVOLUNTARY COMMITMENTS: AN EMPIRICAL STUDY
INTO THE LEGAL CRITERIA USED FOR MENTAL HEALTH COMMITMENTS
IN WAKE COUNTY, NORTH CAROLINA**

**James M. Mullen, Ph.D.
Southeastern Mental Health Center
Wilmington, N.C.**

**Bob Rollins, M.D.
Dorothea Dix Hospital
Raleigh, N.C.**

**Jeffrey L. Stephens
University of North Carolina
Chapel Hill, N.C.**

Although the procedure differs from state to state, involuntary civil commitments (or involuntary hospitalization) always involve the taking of an individual judged to be mentally ill or inebriate from his customary environment and placing him in an institutional setting for custody and treatment. The individual does not initiate the action in such instances; society in the form of a relative, neighbor, law enforcement officer, or other acts on behalf of the individual.

This practice has been attacked by some who focus their arguments on deprivation of basic rights and civil liberties. Most notably, Thomas Szasz (1) has campaigned against involuntary commitment, likening it to enslavement, describing mental hospitals as brainwashing institutions with no regard for the idea of liberty. Szasz has argued that a person should be deprived of his liberty only if he is proved guilty of breaking the law.

Certainly there are involuntary hospitalization laws which leave much to be desired; some take away more liberties than others. But the fact remains that most psychiatrists realize the need for legal machinery which would allow for treatment and custody in certain cases where need is obvious. Siegert (2) lists some of these cases as incompetency due to stupor, acute or chronic brain syndrome, and some instances where serious likelihood of injury to self or others is involved. From a different angle antithetical to Szasz's view, Pezke (3) cites the need for involuntary hospitalization laws so that the ill will not be neglected and be denied the right to treatment. And in regard to the legality of such laws, The American Bar Foundation's study, *The Mentally Disabled and the Law* (4), has this to say about the issue: "To the extent that involuntary hospitalization statutes accord the mentally ill due process of law, their constitutionality is well established." However, they go on to say, "But unfortunately the statutes are so broadly worded they fail to identify with sufficient clarity or precision the type and degree of mental illness for which involuntary hospitalization, with the accompanying deprivation of many personal and civil rights, is justified."

Here arises the very real issue of judicial interpretation of the law. Accepting the need for some involuntary hospitalization procedure which guarantees due process, one must address the question of interpretation of the statutes, since broadly worded statutes loosely interpreted could conceivably allow any given person to be considered a fit subject for hospitalization.

With this thought in mind, let us delve briefly into the North Carolina Involuntary Civil Commitment statutes (GS-122-58, Article 5A). This body of laws was drafted and

ratified in 1973 and revamped in 1974. Prior to 1973 there were two procedures for involuntary hospitalization: Emergency Hospitalization and Involuntary Hospitalization by Medical Certification. The present study deals with the 1974 revised law stemming from these confusing Medical Certification statutes. For any person to be committed by medical certification, the law required only the notarized certification of two qualified physicians, "...any person is mentally ill or an inebriate, and is in need of care and treatment in a hospital for the mentally ill or inebriate." (GS-122-58, Art. 5A, 1964—repealed 1973). No judge at any time ruled on the merits of the case. If objection was made by the individual or a family member, the clerk of court was required to hold an "informal hearing" without "unnecessary delay." In 1973 this so-called two psychiatrist evaluatory commitment was ruled unconstitutional, and the state legislature wrote new involuntary commitment laws.

Summarily, this reform legislation states that no person can be committed unless he is determined to be dangerous to himself or others or gravely disabled. Due process is evidenced by the right to a public hearing within ten days of the date the respondent was taken into custody, by the right to counsel, by the right to appear at the hearing, and by the right to confront and cross examine witnesses. Two medical examinations occur: the preliminary examination within 24 hours of time of custody, and the final examination, both conducted by "qualified physicians," (a psychiatrist at a state mental hospital in North Carolina, in all cases in this study). It is possible for all proceedings against the respondent to be terminated by authority of the magistrate within 72 hours of time of custody. The magistrate's function is to weigh and consider any oral testimony and the written opinion of the qualified physician conducting the preliminary medical examination. The magistrate can either release the respondent or send him to an authorized treatment facility (any mental health clinic or hospital administered by the State of North Carolina) for final evaluation pending the hearing.

The 1974 revision of the law remained essentially the same with one important difference. The criteria for commitment were changed from an "either/or" situation to an "and" situation. Now no person can be involuntarily committed in North Carolina unless he is mentally ill or an inebriate *and* imminently dangerous to himself or others. The law further requires clear, cogent, and convincing evidence of both these criteria in order to support a commitment order. Finally, it should be noted that "inebriate," "mentally ill," and "dangerous to self" are defined in the statutes, but "dangerous to others" is not.

Method

One hundred judicial hospitalization cases from the Superior Court files of individuals processed during June through December of 1974 were examined. Fifty randomly selected cases resulted in 90 day commitments to a mental hospital. The other fifty randomly selected cases resulted in dismissal of the petition and release of the respondent.

Eight key documents which outline the commitment process were studied. These were the following: 1) Petition; 2) Preliminary Medical Report; 3) Order of the Magistrate; 4) Financial Information Questionnaire; 5) Appointment of Council Notice; 6) Notice of Waiver (of right to appear at hearing), if any; 7) Final Medical Report (recommendation of the State psychiatrist); and 8) the Court Order. In the 100 cases under study, 37 demographic and clinical variables gleaned from these documents were cross-tabulated with the Court Order variable to commit or not

commit. A chi-square analysis yielded the significant and non-significant relationships discussed below.

From these relationships we developed demographic and clinical profiles of those committed and not committed and compared the two groups. We then determined the concurrence rate between psychiatric recommendations and Court Orders. Stated another way, our aim was to find who is being committed and why, and under what circumstances did the judicial process deviate from the medical recommendations. These findings should lend insight into how the new law is being interpreted and implemented. Is the actual practice of the law, indeed, within the spirit of the law?

Results

Demographics

There were no significant differences between the committed and non-committed groups for age, marital status, petitioner, and relatives. There were significant differences between the groups for sex and race. A profile of those committed shows an average age of 42 and an age range of 14 to 81. Forty-two per cent were male and 58 per cent were female. Only 2 races were represented; 30 per cent were white and 70 per cent were black. Thirty-two per cent of those committed were single, 28 per cent were married, 14 per cent divorced, and 12 per cent widowed. Petitioners included relatives (52 per cent), law enforcement officers (34 per cent), and other, usually neighbors (14 per cent). Most of those committed had relatives; in fact, 44 per cent lived with relatives (including spouses). Thirty-four per cent had relatives in Wake County, 6 per cent had relatives elsewhere, mostly in other parts of North Carolina, and 16 per cent had no relatives at all.

Sixty per cent of the total sample were male and 40 per cent female. Yet only 35 per cent of the males were committed, whereas 72.5 per cent of the females were committed ($p = .0005$). The racial distribution was similarly striking. Forty-five persons studied were white and 55 were black. One third of the whites and two-thirds of the blacks were committed ($p = .005$).

Turning to another variable, it was shown that 75 per cent of those committed waived the right to appear at their hearing. Of those non-committed, only 36 per cent waived their right to appear ($p = .001$).

Clinical Information

The medical examination and evaluation form filled out by a State psychiatrist (in all cases from Dorothea Dix Hospital) contained a section on the physical condition of the respondent. Descriptions under this section covered a broad spectrum, e.g. aggressive, lacerations, depressed, normal, etc. Large differences occurred between the two groups in two descriptive categories. Forty-two per cent of the committed group showed actual physical injuries, lacerations, burns, or the like, while only 18 per cent of the non-committed group demonstrated such signs. None of the committed group was intoxicated upon examination, whereas 16 per cent of the other group were.

Table 1 presents the diagnostic profile of the entire sample. Differences between the two groups were large in most diagnostic categories, yielding a significance level of $p = .0001$. Table 2 presents the concurrence rate between psychiatric recommendations and court orders. The State psychiatrists recommended commitment in 60 cases. Fifty, of course, were actually committed. In every instance in which the psychiatric recommendation was to release the respondent, the Court complied.

Hence, the Court deviated from the recommendation in only 10 cases, yielding a concurrence rate of 90 per cent.

Table 1. Tentative Diagnosis Prior to Hearing (N = 100).

Diagnostic Category	Committed		Non-Committed		Total Sample	
	No.	Per cent	No.	Per cent	No.	Per cent
Schizophrenia	25	50	5	10	30	30
Episodic Alcoholism	2	4	26	52	28	28
Other Organic Disorders	10	20	1	2	11	11
Personality Disorders	3	6	4	8	7	7
Acute Alcoholism	0	0	6	12	6	6
Affective Disorders	4	8	1	2	5	5
Senile Disorders	4	8	1	2	5	5
Mental Retardation	2	4	2	4	4	4
Undiagnosed	0	0	4	8	4	4

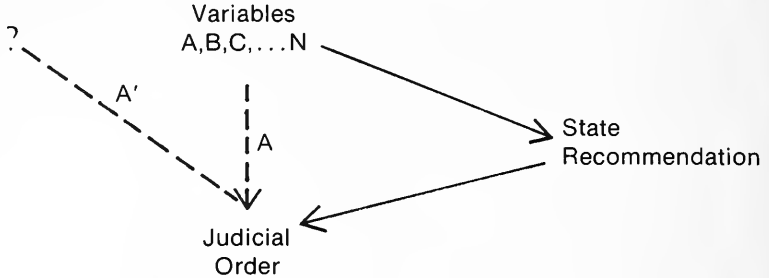
Several characteristics of this group of 10 exceptional cases stand out. The average age was 34.8; eight of the 10 were 35 and younger. Eight were male, two were female. Nine did not waive the right to appear at their hearing; one did not appear. And 7 were judged to have a normal physical condition; three exhibited abnormal physical symptoms. A complete profile of this group is given in Table 2.

Table 2. Profile of Cases Where Court Disagreed With Psychiatric Recommendation.

Case	Marital Status					Characteristics					Physical Condition	Court Order
	Age	Sex	Race	Status	Relatives	Waiver	Tentative Diagnosis					
1	28	M	W	Separated	Non-Local	No	Undiagnosed				Normal	Non-Commit
2	35	M	B	Married	Lives With	No	Episodic Alcoholism				Normal	Non-Commit
3	35	F	B	Divorced	Local	No	Mental Retardation				Bruise	Non-Commit
4	67	M	W	Divorced	Local	No	Schizophrenia				Hip Injury	Non-Commit
5	27	F	W	Divorced	None	No	Personality Disorder				Normal	Non-Commit
6	65	M	W	Married	Lives With	No	Undiagnosed				Normal	Non-Commit
7	27	M	B	Single	Local	No	Schizophrenia				Normal	Non-Commit
8	22	M	W	Married	Lives With	Yes	Personality Disorder				Normal	Non-Commit
9	22	M	B	Single	Local	No	Chronic Alcoholism				Normal	Non-Commit
10	22	M	W	Single	Local	No	Mental Retardation				Seizures	Non-Commit
Totals	34.8	8M 2F	6W 4B	3 Married 3 Divorced 3 Single 1 Separated	4 Lives With 4 Local 1 Non-Local 1 None	9 No 1 Yes	2 Undiagnosed 2 Mental Retardation 2 Personality Disorder 2 Schizophrenia 1 Chronic Alcoholism 1 Episodic Alcoholism				7 Normal 3 Other	10 Non-Commit

Discussion

With the aim of understanding how judges are interpreting the commitment laws, we should first make note of the obvious: Judges are still relying heavily on psychiatric opinion. A model of the commitment process was considered in which all significant variables had some bearing on the Court Order. This model was discarded when it was noted that the Court Order, as a rule, contained the phrase, "...Upon recommendation of the State. . . .": Furthermore, in those instances where commitment was ordered, the reasons given were almost always the exact words of the State psychiatrist. Diagram 1 illustrates what we think to be the correct model of the commitment decision.



Here the State recommendation is based on the clinical and demographic variables, and the Court Order is based on the State recommendations. The dotted arrows represent variations from this stated path. They indicate those factors influencing the court in those cases in which it disagrees with the State recommendation. They could emanate from the clinical and demographic variables included in this study (A) or from variables lying outside the system that we did not include (A').

If this model is accepted, one must speak in terms of variables that distinguish between committed and noncommitted rather than variables which influence the judge's decision to commit or not commit. Biases, if any, would for the most part appear to be attributed to the psychiatrist. The significant differences that did occur can be easily explained by the fact that the State recommendation is based upon the demographic and clinical variables.

The ten cases of disagreement demand special attention as they seem to indicate independent judicial reasoning. Certain characteristics stand out in this group which when taken together ostensibly have the power to override an unfavorable recommendation. The group is biased toward youth with an average age of 34.8 years versus 42 years for all cases of commitment. Had the psychiatric recommendation been followed in these ten cases, no age difference between the committed and non-committed groups would have showed up. As it stands, however, the judge's disagreement in these instances was enough to establish a slight trend. Individuals over the age of 44 are over-represented in the commitment category. Youth is seemingly being perceived as a positive attribute by the judges and as one gets older his chances of being committed are greater. An appearance at the hearing also appears to influence a judge, as 9 of 10 of these respondents did not waive their right to appear. Of those 50 cases where the Court agreed with the psychiatric recommendation to commit, only 30 per cent appeared for the hearing. Also 70 per cent of this group was rated physically normal on medical

examination. In the entire sample of 100, males were under-represented in the commitment category. Traditionally the male is considered better able to care for himself, and this type of thinking could have entered into the decision. In short, a physically normal, young male who appears at his hearing stands a better chance of being released than any other profile, regardless of the medical recommendation. No diagnostic category can be added to this profile, as a broad array of diagnoses was distributed across the groups, with none being outstanding.

The alcoholic stands out as a special case in our study. Inebriety is one of the criteria for commitment, and its statutory definition is fairly clear cut, since addiction to alcohol shows up in a number of obvious physiological and behavioral ways. If a diagnosis of alcoholism, then, is not likely to be in question, an alcoholic must be dangerous to himself or others to be involuntarily committed. The results show that 6 per cent of the sample were acute alcoholics and none were committed; and of all the alcoholics, only 2 were committed, both cases of episodic alcoholism. Of the 30 schizophrenics in the study, 25 were committed. This finding demonstrates that the court is agreeing with the medical opinion (passively, if not actively) that schizophrenics are more dangerous than alcoholics. It is difficult to construe a chronic alcoholic not being at least dangerous to himself (Five of the six acute alcoholics in our sample had attendant delirium tremens.), and he certainly is dangerous to others if he drives. Yet the schizophrenic who in some instances was suffering from no more than delusions is considered fit for custody. Something irrational is at work here, and it could stem from the legal definitions themselves.

What constitutes dangerousness is left unspecified in the statutes. Szasz (1), taking note of society's more accepted view of alcoholics but stigmatic view of schizophrenics, claims that "...it is rather *who* he is, and in *what way* he is dangerous..." that really matters, and he appeals for the idea that where protection of the public is a concern, a person should not be deprived of his liberty unless he has broken a law. Oran (5) would allow for prediction of dangerousness but put the burden of proof on the State, requiring them to prove specific facts. Yet with no solid evidence that psychiatrists or others can predict dangerousness (6), the reasonable path to follow is either Szasz's or the elimination of the criterion of dangerousness to others as grounds for commitment. As it stands, the statutes offer a concept but do not define it, thus giving psychiatrists and judges arbitrary powers.

"Dangerousness to self" is written in the statutes as "inability to provide for basic needs for food, clothing, or shelter." (N.C. GS-122-58.2). Ambiguities are evident. How is inability to be determined and to whom does it apply? Does an indigent person automatically fall into this category, or is the definition tantamount to total dependence on another for survival? Where is the line to be drawn?

Finally, the definition of mental illness is as follows:

The words mental illness shall mean an illness which so lessens the capacity of the person to use his customary self control, judgment, and discretion in the conduct of his affairs, and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control. The words "mentally ill" shall mean a person with a mental illness. (N.C. GS-122-36D).

This definition can be described as an embellished tautology, as are so many legal definitions of mental illness.* In simpler terms, it is stated that a mentally ill person is one

who is not normal, who is not his customary self. But no guidelines are offered to indicate when a person is not his customary self, or at what point he qualifies as abnormal. Very little substance is offered, making arbitrary application possible.

In conclusion, it is not surprising, given such statutory language, that 1) the concurrence rate between psychiatrists and judges is a high 90 per cent, and 2) some arbitrariness in judicial decision making is occurring. The thrust of our findings do show that some of the power of the psychiatrist to commit an individual into an institution has been checked by reform legislation. The ten cases of disagreement indicate the judiciary is cautiously testing new ground. But the fact remains that psychiatrists still have the greatest say in institutionalizing individuals with or without their consent. This state of affairs will probably continue until the substantive laws governing such actions are made less ambiguous and more specific.

*The Model Draft Act of the American Legal Institute states that "A mentally ill individual is an individual having psychiatric or other diseases which substantially impair his mental health." (4) This model has been suggested for all states.

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PRIORITIES IN INTERDISCIPLINARY TRAINING IN DEVELOPMENTAL DISABILITIES

**Donald K. Routh, Ph.D., J. Robert Gray, M.P.H., Raymond Schmitt, M.D.,
and Blan Minton, M.S.W.**

**Division for Disorders of Development and Learning
University of North Carolina at Chapel Hill**

Mental health professionals, including psychiatrists, psychologists, and social workers, are often responsible for providing services to individuals with developmental disabilities, i.e., mental retardation, learning disabilities, cerebral palsy, and other related problems. It is the purpose of this article to describe a set of training priorities in the area of developmental disabilities for mental health disciplines as well as for those in allied disciplines as pediatrics, communicative disorders, physical therapy, special education, and the generalist.

The nature of developmental disabilities is such that many different specialties are involved in treatment and care. This creates problems both in the coordination of services and in the coordination of training. Each professional in this field needs first-hand knowledge of what those in neighboring disciplines can offer to the disabled child and his/her family. The need for interdisciplinary training was the purpose for establishing training facilities such as the Division for Disorders of Development and Learning (DDDL) at the University of North Carolina at Chapel Hill.¹

What kinds of training are most important in such a facility as the DDDL? The training program of this interdisciplinary unit and its forerunner (the Developmental Evaluation Clinic at the University of North Carolina at Chapel Hill) has been underway for well over 10 years, and it was assumed some consensus must have developed among the staff as to training priorities. Rating scales were devised to tap this consensus.

A comprehensive outline was first prepared of all of the areas of knowledge and skill in which training might take place in the dozen or so disciplines involved. This turned out to be a rather staggering effort; the resulting outline consisted of 42 pages of single-spaced typed material which staff members felt to be complete. The outline was then condensed to a one page list of 20 major content areas in which training might take place. As an example of this distilling process, the content area heading of "treatment, remediation, and rehabilitation" was developed to subsume such diverse types of knowledge and skills as those involved in the use of medications, counseling techniques, and remedial educational procedures.

These 20 major content areas were listed in different random sequences on single pages, and booklets of 13 such pages were assembled. One of these booklets was distributed to each professional staff member at the DDDL. The 31 staff members participating in the exercise represented 12 specialties, as follows: pediatrics (4 staff members), psychology (6), psychiatry (1), social work (4), communicative disorders, e.g. speech, language, and hearing specialists (4), nursing (2), nutrition (1), occupational therapy (2), pedodontics (1), physical therapy (2), special education (3) and administration (1). On the first page, each staff member was asked to place the content areas in rank order from 1 to 20 in terms of their importance in interdisciplinary training in one of the 12 disciplines. The second page was used to rank the areas for a second discipline, and so on until all disciplines had served as the focus for such a ranking of content areas. The 13th page was used to rank the content areas for an 'interdisciplinary trainee' or a generalist in the field of developmental disabilities.

If the rankings are averaged across all raters and disciplines rated, the resulting rank order of the content areas is as follows, from most to least important in the training process:

1. Treatment, remediation, and rehabilitation.
2. Standard methods of evaluation.
3. Interpreting findings to families.
4. Early intervention.
5. Theory of developmental disorders.
6. Consultation: concepts, roles, and methods.
7. Basic principles of screening.
8. Basic principles of assessment.
9. Experimental or nonstandard methods of evaluation.
10. Prevention of developmental disorders.
11. Research: methods, communication of results, use of findings.
12. History taking.
13. Theory of child development.
14. Making and accepting referrals.
15. Reports and record keeping.
16. Principles of community organization.
17. Advocacy.
18. Professional ethics.
19. Fiscal administration and program planning.
20. Personnel administration.

The three areas receiving top priority in this list are all every day work experiences for all professionals who deal with children and their families in this type of setting. Perhaps the only surprise, in view of the historic focus of developmental evaluation facilities in North Carolina and elsewhere, was that treatment was given first priority, above diagnostic evaluation.

It is doubtful that the raters regarded training in advocacy, professional ethics, and administrative matters (the items given lowest priority) as unimportant in any absolute sense. The ranking procedure, of course, forced some items to be listed last. Some of the raters commented that trainees should be well versed in professional ethics, for example, as part of the basic training in their specialties before interdisciplinary training became appropriate.

Training priorities in the different specialties were quite similar to those in the general list above. The items relating to treatment methods, standard methods of evaluation, and interpreting findings to families were the top three for most individual disciplines, i.e. communicative disorders, nutrition, occupational therapy, pediatrics, physical therapy, psychiatry, psychology, and special education.

In a few fields one of the top three places was taken by an item further down in the general list. Thus, for nurse trainees, "basic principles of screening" replaced "standard methods of evaluation" as a top item. For trainees in pedodontics, "early intervention" was in the top three, replacing "interpreting findings to families." For social work trainees, "consultation: concepts, roles, and methods" replaced "standard methods of evaluation" in the top three.

The fourth item in the priority list separated the different specialties to a greater extent. For the more medically oriented fields (nursing, nutrition, pediatrics, physical

therapy, and psychiatry), the fourth item on the priority list was "early intervention." For the fields of communicative disorders and pedodontics, the fourth item was "theory of developmental disorders." For special education trainees, the fourth item was "basic principles of screening." For occupational therapy trainees it was "experimental or nonstandard methods of evaluation." For social work trainees it was "history taking," and for psychology trainees it was "research."

In summary, the present study revealed considerable consensus across different raters and widely diverse disciplines as to the priorities in training in developmental disabilities. It was judged that the highest priority in training all professionals should be given to methods of treatment, remediation, and rehabilitation. Second, it was judged that professionals working in this area should have thorough training in interpreting findings to families. Beyond this, the priorities diverged somewhat for different types of trainees. For psychiatry, standard methods of evaluation and early intervention were judged to be particularly important. For psychology, standard methods of evaluation and research skills were deemed very important. And for social work, consultation and history taking skills were in third and fourth priority.

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GILLES de la TOURETTE SYNDROME: A REVIEW

Jesse O. Cavenar, Jr., M.D.

James L. Nash, M.D.

and

LCDR Robert Malcolm, MC, USNR

Veterans Administration Hospital*

Durham, N.C.

*The opinions expressed are those of the authors and not the opinions of the U. S. Navy Medical Department nor the U. S. Veterans Administration.

In 1885 Gilles de la Tourette described nine cases of a syndrome which he had seen at the Salpetriere in Paris;¹ through the years it has come to bear his name. The syndrome usually begins in childhood, between school age and puberty. The two pathognomonic features are a compulsive coprolalia, or uttering of obscenities, and tics of various types. The patients may exhibit violent motor tics with spasmodic grimacing of the facial musculature; the movements, which usually begin in the upper part of the body, may affect the whole body. The tics may be expressed by hopping, skipping, jumping, and other complex motor outbursts which involve some degree of coordination. The patients are compelled to utter swear words or obscenities, and may repeatedly call out the words or phrases. The syndrome may progress to the point that the patient has compulsive coughing, barking sounds, or other animal-type noises. This bizarre behaviour is spontaneous and unpredictable but may become worse when the patient is under emotional stress.

This syndrome has been thought to be rare, but several case reports have appeared in the literature in recent years,^{2 3 4 5} suggesting that the syndrome is not as rare as once thought. In some of the reported cases, there is a family history of tics, and the affected children come from families where all the interpersonal relationships were strained. The parents' roles are usually poorly defined for the affected child, and the child is prone to feel rejected, anxious, and resentful.

The etiology of the syndrome is obscure. It has been assumed that some organic pathology of the central nervous system was involved because of the exhibited severe tics and gross movement disorders. However, the electroencephalographic and neurological findings are usually normal, even in the most severe case. Likewise, autopsy findings of long standing cases of the syndrome do not reveal any organic lesion. It is widely assumed, therefore, that Gilles de la Tourette syndrome is of functional origin, with a mixture of hysterical and obsessive symptoms. Dynamically, the syndrome represents an attempt by the patient to draw attention to himself, and also an automatized defensive pattern against his rage. The self-punitive and masochistic elements of the syndrome are pronounced. The coprolalia is both anal and libidinal.

Until the last decade no effective treatment for the syndrome was known. The course of the illness was uniformly a progressive personality deterioration, with eventual institutionalization the inevitable outcome. Various treatments were tried without success, including insulin therapy, electroshock treatment, sedatives, muscle relaxants, behavioral conditioning therapy, and hypnosis. Some minor success was reported with long term supportive therapy of the patient and his family. In the past decade, reports have appeared^{6 7 8} suggesting that haloperidol (Haldol) is the drug of choice for the treatment of this syndrome. This drug is a butyrophenone derivative, and it is a

major neuroleptic and antipsychotic drug. Good control of the symptoms of the syndrome has been reported with dosages of one milligram per day of haloperidol. The long term effects of such maintenance therapy are not known at present.

Since this syndrome is most commonly seen in children, or seen in adults who are institutionalized, it is indeed unusual to find this clinical picture in an active duty sailor who is performing at a satisfactory level. The following history illustrates such a case:

Report of Case

The patient is a twenty three year old single male enlisted sailor with four years of active duty. He was referred to the Neuropsychiatry Clinic of the Navy Regional Medical Center, Charleston, S.C., by his command for psychiatric evaluation because of the recent onset of unusual behavior. The history revealed that he was an only child who had been raised in the southern United States by parents whom he described as hard-working, strict, religious, good people. When he was nine years of age, father suffered a severe myocardial infarction and the patient was instructed to "be quiet" in the home because of father's heart condition. Within months, the patient had the onset of multiple facial tics and coprolalia, manifested by repeatedly muttering and occasionally yelling the word "shit." The family took the patient to a psychiatrist in a large southern city who saw the patient for four years in insight-oriented psychotherapy. The therapy was twice weekly for two years, then once weekly, and finally tapered to once every three months. The patient reported that he made progress, and was completely symptom-free by age thirteen. All that he could recall of his therapy was that he found out "that I was very angry." He finished high school with above average grades, and then entered Naval service. He felt that he had performed well in the Navy and "loved it." He was very insistent that he wanted to make a career of the Navy, and was concerned that the examiner would "throw me out." A review of his service record verified that he had indeed done well during his four years of active duty.

The patient had been asymptomatic until approximately two months prior to psychiatric referral when he had begun to mutter "suck me, sir," and to develop facial tics and grimaces. The onset of these symptoms occurred six months after the death of his father of a myocardial infarction. Several weeks after the father's death the patient had witnessed a pornographic movie in which fellatio was a prominent theme, and he felt this to be related to his coprolalia. After the onset of the above symptoms, he attended another movie entitled *Blazing Saddles* in which black cowboys are featured. Within days, his coprolalia changed to "suck me, sir; I am a nigger." Naturally, his command was greatly concerned over such utterings on board ship, and questioned his fitness for continued active duty.

The mental status examination revealed a friendly, cooperative, very likeable, embarrassed young man who was tense and anxious. He was continually uttering the coprolalia and then apologizing for having done so. He described an inner anxiety or tenseness that would build up in his chest and be relieved only by uttering his profanities. He had multiple facial tics and grimaces without observable movement disorders anywhere else in the body. There was no evidence of any psychotic thought process, affective disturbances, or organicity.

A decision was made to hospitalize the patient for initiation of haloperidol therapy. The physical examination, routine laboratory studies, and neurological consultation was within normal limits. Haloperidol was started at five milligrams h.s., and increased to ten milligrams h.s. after twenty-four hours. On this dosage, the patient showed very

rapid improvement of both the tics and coprolalia. After ninety-six hours of hospitalization, he was essentially symptom-free and was returned to full duty. He was to continue the haloperidol and be seen in outpatient supportive psychotherapy on a once per week basis.

It was felt that this man had achieved good symptom control, was highly motivated for a Naval career, and had much to offer the Navy. He was not felt to have more potential for psychosis than the average person, and was not felt to be a security risk.

Discussion

The dynamics of this patient suggested that he was a very angry man whose rage was strongly repressed. As a latency age child, he was instructed in essence to behave like an adult, and not a child. His rage at these restrictions became symptomatic with the onset of the Gilles de la Tourette syndrome. The profanities he uttered were clearly expressing his unconscious rage, contempt, and rebellion against the parental restrictions. As he was able to understand and make conscious his rage in the course of the psychotherapy, he became asymptomatic.

When he entered adolescence he was unable to behave as an adolescent since he was still under the imposed parental restrictions. As a result he never negotiated adolescence in the sense of rebelling against parental standards and attitudes, dating, sexual experimentation, and developing a firm identity separate from the parents.

The recurrence of symptoms after father's death again served as an outlet for his unconscious rage. In his uttering "suck me, sir," there is a degradation and hostility for the person for whom the message is intended. To the patient's mind, "sucking" is something forbidden, evil, and contemptuous which occurs on a pornographic movie screen. His ambivalence is expressed in the "sir," which implies respect, obedience, and a willingness to follow any command. To the patient, this was the command his parents had given to "be quiet." The addition of "I'm a nigger" to his coprolalia suggest his identification with a group whom he considered to be inferior, downtrodden, oppressed, and viewed with contempt by himself. The masochistic element in the identification was striking.

Summary

A patient is presented who, while successfully carrying out active duty as a sailor, suffered the acute onset of a rare psychiatric syndrome usually seen in children or institutionalized patients. Treatment with psychotropic medication and psychotherapy was successful in allowing his return to regular duties.

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WHY PEOPLE BECOME DRUG DEPENDENT: A REVIEW

Steven Lippmann, M.D.
North Carolina Memorial Hospital
University of North Carolina
Chapel Hill, North Carolina

Throughout history, people have sought ways to change their frame of mind, and segments of almost every society have used drugs with this intent. The drugs with which we are concerned alter mood and/or behavior (i.e., are psychoactive) and are commonly abused. Drugs of greatest current concern are the hallucinogens, stimulants, narcotics, and sedatives (including alcohol, the drug most frequently abused). Nicotine and caffeine are also psychoactive, but acceptable within mores of our culture. Drug dependence is the strong desire to habitually repeat the use of a drug for non-medical reasons. Usually, drug dependence is accompanied by, and continued despite adverse consequences for health, occupation, personal relations, compliance with societal rules, etc. Explanations for drug dependence derive from the fields of medical and behavioral sciences.

BIOLOGICAL EXPLANATIONS: It has been suggested that drug dependence has a metabolic basis. Through a pre-existing abnormality of the central nervous system or its metabolic pathways, a person might have an increased susceptibility to drug dependence from an abnormally strong response of pleasure to drugs. Drug use might be an attempt at self-treatment of a pre-existing metabolic imbalance, such as an abnormal biogenic amine metabolism. The determined way in which many drug users seek drugs has been likened to the implanted electrode self-stimulation experiments in animals, who seek electrical stimulation over all other forms of gratification including food. Another theory postulates permanent derangements within the nervous system following the first drug use cycle.

The protracted withdrawal state is a significant biological factor related to drug dependence. Protracted withdrawal is a subacute withdrawal illness occurring in narcotic users once acute drug withdrawal has ended. It consists of very subtle signs and symptoms of withdrawal lasting six months or more after the subject is drug free, and is a powerful stimulus to drug relapse. Biological factors were cited in the rationale for methadone maintenance, and are reflected in the axiom, "once an addict, always an addict," even though this model does not necessarily state a biological determinant. Severe forms of alcoholism seem to follow genetic inheritance more than environmental influences. Other drug abuses seem to follow familial use of patterns but without a genetic inheritance basis.

Counter to the theories of a purely biological origin for drug dependence is the lack of specific drug-related neuroanatomical or neurochemical abnormalities other than those found in the protracted withdrawal state. Additional counter evidence comes from the fact that experimentally-addicted subjects do not always crave drugs once withdrawn.

LEARNING THEORIES: Both operant and classical conditioning models are used to increase understanding of drug-dependent behavior. Operant conditioning explains drug dependence in that the user gets strong positive reinforcement from drugs, pharmacologically through the direct pleasurable effects of the drug, and socially through peer group acceptance, improved self-image, etc. Many drug users shop

around, sampling a large variety of substances until they learn which ones seem best suited to their emotional needs. For example, an aggressive person might try alcohol, but find that its dysinhibition of the central nervous system makes him behave more aggressively, while a narcotic may help control aggressive urges. Once drugs are used to the point of physiological dependence, factors of conditioned avoidance and negative reinforcement occur and foster continued drug use. Conditioned avoidance is seen when the user, knowing that withdrawal is unpleasant, repeatedly administers drugs to avoid the unpleasant withdrawal state. The user stays one step ahead of withdrawal in a vicious cycle. Negative reinforcement is similar, but operates when the person is already in the withdrawal state, and uses drugs to escape this unpleasant condition.

In the context of the classical conditioning model, the unpleasant withdrawal state is the unconditioned stimulus that leads to the response of desire for relief (achieved by drug-taking behavior). This stimulus-response system occurs in association with social and environmental factors (i. e., the pusher and his neighborhood, etc.) which become conditioned stimuli. Once this paired pattern is learned, the mere presence of a conditioned stimulus (e. g., the pusher) kindles the strong desire for drug-taking behavior. This may occur despite years of drug abstinence and otherwise no desire for drugs. It has further been stated that the conditioned stimulus can elicit actual signs and symptoms of a withdrawal state. Another not uncommon occurrence is that the drug user may misinterpret the normal signs and symptoms of anxiety as being those of impending withdrawal, and then self-medicate to avoid a withdrawal which is not actually imminent.

SOCIO-ECONOMIC ASPECTS: Drug use occurs frequently in family groups. Usually these are troubled families, often beset with criminality, drug dependence (especially alcoholism), and emotionally or physically absent parents. These families are more likely to live in situations where a drug escape from the hopelessness of reality is attractive, and where there is a concentration of drug-using role models. This environment is more likely to foster development of drug use as a way of coping with life stresses, with a resultant paucity of non-drug related coping skills. Socio-cultural contagion theories stress the importance of fads, drug availability, and peer influence as primary factors in drug use. The importance of fads and drug availability can be seen, for example, when one examines the changing patterns of opiate use in this country. In the last century, narcotics were often used by white rural southern women, while in this century, use is more frequent among minority group males in urban northern areas. Fads and drug availability also influence drug choice, for example, the use of Demerol among physicians while heroin is confined to street users. Peer influence is another major factor in drug use — for kindling curiosity, for first drug exposure, for continued use, and for drug pushing. Most pushers are friends of the users. Drug use by peers is a greater influence to taking drugs than is the family drug-using pattern. Peers give strong pressure for conformity to drug-using standards, and reward drug use with friendship, a sense of belonging, etc. Great importance is placed on the drug as a symbol which confers status, demonstrates defiance of authority figures, etc.

The medical profession is another pusher in our society. Physicians often treat discomfort as an illness which requires a drug treatment, or prescribe drugs when counseling or other therapies are more indicated. People medicate themselves in much the same manner, and make strong demands on physicians to prescribe drugs. In our

drug-oriented culture, the media constantly espouse the positive benefits of drugs (e. g., alcohol and others). Economic motives promote drug use. These are obvious when considering distillers or cigarette manufacturers, etc., but are also present in the pharmaceutical industry, and of course the illegitimate drug market, etc. Political influences foster society's tolerance of dangerous drugs on the market and allow the inappropriate use of drugs to continue (e. g., driving while drunk, a permissive approach to illicit drugs confined to deprived areas, etc.).

PSYCHOANALYTIC CONTRIBUTIONS: The drug user is generally characterized as having an oral personality, i.e., dependent, narcissistic, immature, with low self-esteem. Drug users are said to have an impulsive, demanding life-style with poor object relations. This demanding, yet dependent style is compared to that of an infant. All desires are communicated as demands for total and instant care. As an adult, this leads to frustration and depression. Some drugs can produce a type of euphoria which decreases this depression, and the user gradually replaces other forms of gratification with these drugs. However, drug use results in guilt, increasing the depression and therefore increasing the desire for drugs. This continues in a vicious cycle, with guilt about drug use reinforcing the continued use. In some cases, drugs are used to block sexual and/or aggressive drives. Many drug-dependent persons act as if they are unable to live without drugs, or as if any anxiety in life is a major traumatic event for which drugs are the answer. There are many psychodynamic theories of drug dependence and their various unconscious ramifications which vary according to authors and cases (e.g., use of drugs as a symbol for union with lost parents, drug use to insure defeat in persons with success phobias, etc.). The cause is often attributed to an abnormality of early development, most commonly an over-indulged or deprived life as a young child. Deprivation is the most commonly cited cause, and is characterized by an unloving, neglectful mother and a passive, inadequate, or absent father. The aggressive street addict probably comes from the deprived situation, while the passive-dependent user derives from the over-indulged group.

EMOTIONAL ILLNESS FACTORS: Drug dependence is highly correlated with all types of depression, and depression seems to be the most common emotional concomitant of drug dependence. Depression can exist with all of its classical signs and symptoms, or it can be masked. Suicide rates are over five times that of the non-drug-using population, without consideration of deaths by accidents, cirrhosis, overdose, etc. The self-destructive effects of drugs are often well-known to users, but frequently denied. However, aspects of a suicide equivalent or death-wish could be present on either a conscious or unconscious level. Drug self-treatment of depression is common among drug users. Neurosis can be predisposing condition toward drug use also; however, there is no single experimentally-reliable factor which can be identified prospectively. The core of addictive impulses as a neurotic element exists in almost everyone, particularly if one includes abuses of food, candy, coffee, and smoking, to say nothing of abuses of alcohol or other drugs.

As far as is known, drugs do not cause or result in functional psychosis; however, there are high rates of association between schizophrenia and drug use, particularly in middle-class teenagers on amphetamines or hallucinogens. One reason for high rates of schizophrenic diagnosis is that the psychiatric profession usually sees the emotionally disturbed users and troubled adolescents who appear worse in crises than they really are. Many of these cases may simply be toxic psychoses, misdiagnosed as

schizophrenia, since often in acute cases they cannot be differentiated. Toxic psychoses are studied to increase understanding of functional psychoses, and it appears that hallucinogens and stimulants might precipitate latent psychoses. With a variety of drugs, many users self-medicate symptoms of major psychotic illnesses (e.g., to obliterate bothersome hallucinations, etc.), and drugs may provide strengthening of defenses for some psychotic or borderline persons. Additionally, drugs provide social contacts through the drug-using subculture that might be otherwise unavailable.

Character disorders, particularly sociopathy, are also very frequently diagnosed in this population and may even be a predisposing factor, particularly in the thrill-seeking aspects. On the other hand, sociopathy seems over-used as a diagnostic category, since many drug users have good object relations, superego, and normal sense of guilt. Also, crime is not universal among drug users. Crime, in providing the subject with an action-oriented and impulsive life, may act as a defense against depression rather than being a symptom of sociopathy.

In general, it has been noted that the greater the number of different drugs an individual uses, the greater is the likelihood that emotional illness is a causative factor in the drug use. Similarly, the more a person's drug use pattern deviates from that of his social group, the greater is the chance that psychopathology plays a causative role.

In summary, there are a large number of theories and explanations offered for why people become drug dependent. However, there is no single explanation and no single "addictive personality type." More likely, various drugs are used for varying reasons by different people at different times. Expression of overt drug dependence probably depends on an interplay between multiple predisposing physical, social, and emotional factors.

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EVALUATION OF ADOLESCENT TREATMENT NEEDS AND ASSESSMENT OF SERVICE DEFICIENCIES IN TREATMENT & FOLLOW-UP OF HOSPITALIZED ADOLESCENTS

**Kenneth A. Naylor, M.D.
Raleigh, North Carolina**

**Billie F. Cordea, Ed.D.
Dorothea Dix Hospital
Raleigh, North Carolina**

This research project covered a period of one year, and involved all adolescent admissions through age 18 years to a regional state mental hospital admissions unit. This is a mixed admissions unit for all age groups except young children, and there is, as yet, no separate adolescent inpatient unit in the hospital. Consequently, the adolescents are admitted to two adult wards, one male, one female, each with about 70 to 80 patients.

The patients are referred by various counties in a mental health region of North Carolina; all those referred are admitted without any screening process at the hospital. There is, however, a screening evaluation at the source of the referral, usually a mental health clinic, although the method of this operation is unclear at present.

This study addresses itself only to those patients admitted to the Psychiatric Admissions Unit. We did not include forensic admissions in the study, but we did keep a tally of these patients for comparison.

Method

All adolescents admitted to the Inpatient Admissions Unit were evaluated within several days of admissions by administering the following battery of tests:

1. the Devereux Adolescent Behavior Rating Scale,
2. the Bender-Gestalt,
3. the Draw-A-Person Test,
4. and the Comprehension and Similarities subtests of the Weschler Intelligence Scale for Children or the Weschler Adult Intelligence Scale.

A referral information form was completed with information from referral sources which covered the following areas and questions:

1. What reasons were given for hospital commitment or admission by the referring agency or guardian?
2. Why was the patient not treated in his own community?
3. Lists of agencies involved in the referral or commitment procedures were obtained.
4. Explanations of any juvenile court charges were obtained.
5. Lists of agencies which were potentially available within the community which might have offered treatment were obtained.

Follow-up studies were conducted at two weeks and two months after discharge. Most of this information could be obtained by telephone from the referral agency, but sometimes it was difficult to contact anyone connected with the patient; and we resorted to the use of a questionnaire letter which was only sent when all other avenues of contact had been exhausted.

The study evaluated this adolescent population from the following aspects:

Statistical Information

1. Number, age, and sex of patient including age range.
2. Source of referral.
3. Reasons for admission, that is, presenting problems.
4. History of previous hospitalizations in a mental health facility.
5. History of previous involvement with the police.
6. Type of admission.
7. Duration of stay in hospital.

Diagnostic Evaluation and Treatment Modality During Hospitalization

1. Ward diagnosis and I.Q. rating.
2. Diagnosis by Devereux Scale and adolescent conference.

Type of Treatment Which They Received While in Hospital

Follow-Up Evaluations

1. Two weeks.
2. Two months.

Results

Statistical Information

1. Number, age, and sex of admission:

Total admissions	145
Total number of males	72
Total number of females	73
Total number discharged	108
Total number of male adolescent forsenic admissions during the same period	94

2. Age range of these admissions:

Age	Number Admitted	Percentage
18	49	34%
17	37	36%
16	15	10%
15	16	11%
14	13	9%
13	10	7%
12	3	2%
11	2	1.5%
	145	100%

The 94 male adolescent admissions for the Forsenic Unit had the following age range:

18	40	42%
17	20	21%
16	25	26%
15	6	6%
14	2	2%
13	0	0%
12	1	1%
Total 94		

Consequently, in this study the greatest number of admissions to the general psychiatric unit, that is 69%, occurred in the age range of 16 to 18, inclusive. In the forsenic group, the same age range accounted for 89% of admissions. In the age range of 11 to 13, there were only 10.5% of all admissions.

These figures suggest that the disturbed, and disturbing, adolescent is more easily recognized and dealt with by hospital admission the older he becomes and, possibly, that symptoms unrecognized in the earlier years are more readily identified later. However, there are other factors which will be discussed later, including the fact that patients as severely disturbed as these frequently come to the attention of the authorities, usually at a point when society can no longer tolerate their disturbing behavior.

3. Source of referral:

Source	Number
Mental Health Clinic	70
Self-referral	10
County Hospital	21
Department of Corrections	4
Court Referrals	18
Private M.D.	6
Other Agencies	16

The majority were, therefore, referred either by a mental health or other medical agency; and very few, that is less than 3%, came from private practitioners.

4. History of previous hospitalizations in a mental health facility:

- 29 patients had one prior hospitalization(s)
- 14 patients had two prior hospitalization(s)
- 3 patients had three prior hospitalization(s)
- 1 patients had four prior hospitalization(s)
- 1 patients had five prior hospitalization(s)

Therefore, out of the total number of 145 admissions, 97 had never been admitted to a psychiatric facility previously.

5. History of previous involvement with the police:
This was obtained in 46 cases for the following reasons:

Type of Delinquent Behavior	Number
Truancy, runaway, etc.	10
Drug charges	8
Breaking and entering	13
Assault	4
Armed Robbery	2
Abducting a child	1
Concealing a birth	1
Shoplifting	1
Destroying property	1
Forgery	1
Contributing to the delinquency of a minor	1
On probation - reasons unknown	2
	45

6. Duration of stay in hospital:

Duration	Number
Less than 1 day	8
Less than 7 days	37
7 to 30 days	30
30 to 60 days	19
60 to 90 days	5
More than 90 days	9
Total	108

The remaining 37 were still in the hospital when the study was completed.

7. Type of admission:

Type	Number
Involuntary Hospital Admission	77
Voluntary Hospital Admission	44
Emergency Hospital Admission	7
County Court Order	7

The 7 referred by the court were female forensic adolescents who were admitted for psychiatric evaluation before going to trial.

8. Reasons for admission:

Problem	Number
Suicide Attempts	26
Aggressive Behavior	12
Psychosis	20
Court Evaluation or Alcoholism	9
Drug Addiction	10
Mental Retardation	13
Chronic Brain Syndrome	4
Inappropriate Admission, i.e., dumped for various reasons	6

The 13 cases of mental retardation were patients from the O'Berry Center in Goldsboro, North Carolina, who were referred because of disturbed behavior which could not be handled by that center. The inappropriate admissions were patients who were usually scapegoats for family conflicts, and several of these were brought to the hospital by relatives or friends who did not stay long enough for a detailed history to be obtained. Sometimes they were driven many miles late at night, dropped off at the hospital with a brief explanation of their admission request. Follow-up of these patients often proved difficult.

Diagnostic Evaluation

Each adolescent was under the care of one of the adult psychiatrists assisted by psychologists, social workers, and nurses. The psychiatrist in charge could either be a staff psychiatrist of a resident in training, and sometimes a medical student. Although psychologists were available on the adult wards, during the period of study they were usually part-time and inexperienced in the specific problems of adolescents. Consequently, expert psychological opinion was only available through the Child Psychiatry Training Services and was obtainable by a consultation request. Only in a small number of cases was this request made, but all the patients received an educational evaluation which included some psychological testing carried out by one of the teachers. The social work evaluation was carried out by one of the professionals attached to the Admissions Unit and was usually adequate provided a contact could be made with one or both parents. This was not always possible with the result that in many cases the background information was meager.

Very few of the adolescent admissions were seen by either a child psychiatrist or child psychologist on a consultation basis, and neither were the services of psycho-educational consultants utilized adequately. In fact, the only patients who had comprehensive workups were those who were presented to the weekly adolescent conference, and the majority of these were not direct consult requests. Consequently, most of the patients were evaluated, given a diagnostic label, and a disposition made without reference to child psychiatric specialists.

The following is a breakdown of the diagnostic categories as recorded in the patients' charts:

Diagnosis	Code
Psychosis	36
Depressive Reaction	17

Mental Retardation	10
Drug Dependency and Abuse	17
Adolescent Adjustment Reaction	23
Alcohol Intoxication	8
Organic Brain Syndrome	8
Behavioral Disorder of Adolescence	2
Unsocialized Aggressive Disorder	5
Hyperkinesis	4
Passive-Aggressive Personality	2
Inadequate Personality	1
Inappropriate Hospitalization Due to Argument With Mother	1

Assessment of the I.Q. range of the patients was obtained from a variety of sources including ward psychological testing, educational testing, and, in some cases, through the use of the WISC by one of our child psychologists. The following results were obtained:

I.Q. Rating	Percentage of Cases
Less than 50	1.5%
50-59	14%
60-69	14%
70-79	26%
80-89	15%
90-99	18%
100-109	5.5%
110-119	1.5%
120-130	4%

Consequently, only 11.5% of the admissions had an estimated I.Q. of greater than 100, and approximately 55% of all the patients had an I.Q. rating of less than 80. Of the total, 9 out of 10 admissions were in the dull normal range or below. In addition, many of the patients had multiple handicaps including psychosis, drug addiction, depression, and various other emotional disturbance.

Follow-Up Studies

Following discharge from the hospital, attempts were made to contact the patients at two weeks and again at two months. While contact with the patient was not always possible, there was usually someone such as a social worker, therapist, administrator, or relative from whom the pertinent information could be obtained. Since most of the adolescents were referred back to the mental health clinic originally referring them, this was usually the first place contacted; and in our experience they generally proved to be interested and helpful although the whereabouts of some of the patients was difficult to establish. Most of the follow-up work was done by telephone; but in the event that information was not available by this means, a letter was sent, in the form of a questionnaire, asking the patient, responsible relative or caretaker to answer a few basic questions regarding follow-up care.

For the total number of admissions during the year, the following is a breakdown of the follow-up studies:

At two weeks after discharge from hospital -

Facility	Number
Being seen at mental health clinic	37 (34%)
Type of therapy provided in clinic:	
individual	32
day hospital	3
parents only for counseling	2
Admitted to another inpatient facility	5 (4.6%)
Seeing a private psychiatrist	5 (4.6%)
In prison or jail	3 (2.8%)
Readmitted to regional state mental hospital	9 (8.3%)
Not involved in treatment	48 (44%)
University counseling center	1

The category “Not Involved in Treatment” was more closely looked at with the following results:

Twenty-one patients were unable to give a reason for not being involved in treatment, and sixteen patients had refused to be involved in treatment or felt that it was unnecessary for various reasons. One patient gave the excuse that he could not get to a therapist because of lack of transportation, and two patients had run away and were not involved in treatment.

In addition to the above, eight could not be contacted and did not respond to our questionnaire letter.

Follow-up at two months after discharge -

Facility	Number
Being seen at a mental health clinic	33
This was further broken down into the types of therapy involved, and the figures for this are as follows:	
Individual therapy	29
Day hospital	2
Parents only for counseling	2
Had been to mental health clinic but had discontinued treatment	6 (6.12%)
Admitted to another inpatient facility	3 (3.06%)
In prison or jail	2 (2.04%)
Seeing a private psychiatrist	6 (6.12%)
Readmitted to regional state mental hospital	13 (13.26%)
Not involved in treatment	34 (34.69%)
University counseling center	1

Of those patients, that is 13, who had been readmitted to the regional state mental hospital at two months after discharge, 4 had been seen for follow-up in a mental health facility; and 9 of them had received no treatment at all.

An evaluation of the referral by county was also carried out, and the attached table shows the number admitted from each county, number actually referred by that particular mental health clinic, the number followed up, and the number of patients treated at the mental clinic at some time following release.

Discussion of Results and Assessment of Deficiencies

The study was primarily involved with the needs of those adolescents admitted to the Central Admissions Unit, and our concern was with the availability or non-availability of services for them. We were particularly concerned with service deficiencies, and the results suggest the following areas for concern:

First, they did not receive specialized care either by a full-time or even part-time child psychiatrist or child psychologist.

Second, the total number of adolescents admitted to the hospital was 239, of which 94 were male forensic patients and a further 7 were female forensic admissions. Consequently, 101 patients were admitted by court order for psychiatric evaluation prior to their hearing. These figures suggest that while it is possible to present a case for the employment of full-time specialized staff working in a separate adolescent unit, it is also possible to make a good case for the recruitment of full-time specialist staff in a forensic adolescent unit. In fact, since the forensic patients usually stayed at least 30 days and sometimes much longer, up to 90 days, and are presently housed with adult offenders, there appears to be a need for a separate forensic unit serving adolescent offenders. If this is taken a step further to include the 46 patients in the study who had a previous history of involvement with the police, but whose current admission was due to an emotional disturbance unrelated to crime, we arrive at the figure of 148 adolescents who either had previously been or presently were involved in antisocial activities of sufficient degree to bring them to the attention of the police. This group accounts for 61% of all admissions and supports a strong case for the availability of psychologists and psychiatrists who are especially familiar with the needs of these patients and who have some expertise in legal psychiatry. It might even be possible to offer trainees in child psychiatry, including residents, psychologists, social workers, and liaison teachers, an enriching rotation in this field.

Third, a majority of the patients in the study did not receive what would be regarded as an adequate diagnostic workup as measured by the present standards of child training. This would normally include parent or guardian interviews, psychological testing, educational evaluation, and pediatric evaluation in addition to patient interviews. However, some of these deficiencies were explainable, at least in part, by the unavailability of relatives usually because of family disorganization. Consequently, a detailed family and social history was frequently unobtainable although, given time, it was usually possible to piece together information from various sources in sufficient quantity to give us some broad idea of the patient's background. Nevertheless, in some cases it was difficult to obtain even a basic history, and in some cases the reasons for admission were unclear. Sometimes a patient would be discharged within a few days of admission, making the assembly of background information impossible. This was particularly noticeable with patients admitted for alcohol and drug problems. Generally speaking, the longer they stayed, the more likely were we to obtain details of family and social background; and we were able to demonstrate through the adolescent

conference presentations that even in the most despairing of cases, a coherent evaluation could be assembled and an appropriate disposition recommended.

Of all the diagnostic modalities available, the most consistently applied was the educational one; and although there were difficulties in organizing this, every adolescent who remained for more than a week received an educational assessment by members of the hospital school staff, and many of them subsequently attended the facility on a regular basis. In addition to its educational assets, the school also served a therapeutic role and this will be discussed later.

Fourth, an important deficiency was the almost total absence of organized psychotherapeutic services for adolescents on the admissions unit. There were no regular group sessions, few regularly assigned individual psychotherapists, and no evidence of any behavior modification system. In fact, there was no identifiable therapeutic inpatient plan for these adolescents while they remained on the inpatient admissions unit. The most likely explanation for this is that the services were oriented primarily towards adult patients who represented some 90% of the population. It was a major task to handle this number of severely disturbed adults, and there was little staff time available for the specialized needs of a relatively small and fluctuating adolescent population.

Fifth, a deficiency with which this study was particularly concerned was that of follow-up. This was especially important since we were thinking in terms of the development of an adolescent inpatient unit at some time in the future, and it seemed important to us to determine not only the type of adolescent admitted but also where they came from and where they went.

Since each county in the region is served by a mental health clinic and since this hospital is the only state mental facility serving this region, it might be expected that a large proportion of admissions would be referred directly by these clinics and, therefore, referred back to these sources for post-hospitalization care. However, as shown in the table, only about 50% of our admissions were direct referrals from a mental health clinic, and follow-up of these indicated that only about two-thirds of them had been treated at some time in a mental health facility following release from the hospital. The follow-up studies at two weeks indicated that approximately 34% of the patients were being seen at this time in a mental health clinic, and this figure had decreased slightly at the two-month follow-up period, some 30% being seen at that time.

An examination of the referrals by individual clinics seems to confirm these figures although there is considerable variability from clinic to clinic. For example, the largest referral source, that is the facility immediately attached to the hospital, referred 14 patients of which only 7 could be shown to have received some treatment at some time in that facility following discharge from the hospital.

The reasons for this poor attendance at mental health clinics are not clear since most of them are able to offer post-hospitalization care in the form of individual therapy, parent counseling, group psychotherapy, and the facilities of a day hospital. Not all of them have specialized children's services, but even those who do not have this are still able to offer an adequate aftercare program for adolescents. The follow-up study suggested that those adolescents being treated were mainly being seen in individual psychotherapy, and only a small number were being seen in the day hospital. Two of the cases were being treated indirectly by parent counseling.

When studying the follow-up care of these adolescents, it is important to bear in mind that nearly all of them were seriously disturbed and disturbing and had frequently been

admitted to the hospital at a time when attempts at outpatient treatment had failed and when community resources had been exhausted. As stated previously, many had already been involved with the police in one way or another; and of the others, quite a number had exhibited potentially violent behavior sufficient to cause concern in their home environment. Some were psychotic, some retarded, and some impulse ridden. Others represented a combination of disorders, and some were already identified as either alcoholic and/or drug abusers.

Consequently, arrangements for the follow-up and aftercare constitute an important part of treatment in addition to providing valuable information to those involved in the planning and development of an inpatient adolescent unit within the state hospital facility.

It was, therefore, rather alarming to discover that at two weeks after discharge, some 44% of the patients were not involved in any form of treatment; and this figure was only slightly reduced, to 34%, at the two-month follow-up point. We can say then, with a fair degree of certainty, that of all patients in this age group being discharged from the hospital, at least a third never become involved in any type of aftercare treatment. As mentioned previously, most were unable to give a reason for not being involved in treatment, many had refused to be involved, and some of them could not be contacted and did not respond to the questionnaire letter.

Follow-up study of the remaining patients revealed the depressing information that at the end of two weeks following discharge, approximately 13% had been readmitted either to the regional state mental hospital or to another inpatient facility and that about 3% were in prison or jail. When studied at two months, the number of readmissions had increased to 16% and there were a further 2% in jail. This information suggests that this group of patients was discharged from the hospital prematurely, and a better disposition might have been to a long-term inpatient facility.

Only a small number, approximately 1 in 20, were being seen by private psychiatrists; and this figure was consistent both at the two-week and two-month follow-up points.

The result of this follow-up study then seems to suggest that about one-third of the patients were being seen in a mental health clinic, rather more than one-third were not being seen anywhere, and the remainder were distributed between jail, readmission to the hospital, private psychiatrists, and one patient being seen in a university counseling center. It would seem, therefore, that between one-half and two-thirds of the patients discharged were receiving no treatment at all since they were either not being seen anywhere for various reasons or were in jail or had been readmitted to the same admissions unit, which, as shown previously, was unable to provide suitable treatment facilities.

In spite of the above-mentioned deficiencies in both diagnostic evaluations and after care facilities, there were several treatment modalities available in the hospital which were offered to a limited number of adolescents. A small number of patients were transferred at intervals from the admissions unit to one or other of the of the various geographic units. One of these units, the Therapeutic Community, took most of these patients and was able to offer both group and individual psychotherapy. Attempts were also made to arrange family therapy sessions in one or two instances. These adolescents, together with a few others in other units, were invariably involved in a continuing educational program which catered to junior and high school students and which, in addition to being oriented to cognitive development, was also concerned with behavioral control. The school requires that both the student and his parents shall be

involved in regular psychotherapy, and although this is sometimes difficult to enforce, pressures to conform are vigorously applied.

It seems, therefore, that those adolescents who become involved in comprehensive treatment and educational programs were the few who stayed longest and who were transferred away from the Admissions Unit. Also, since some of the patients in the school come in each day from the surrounding community, the net result was a joint inpatient/day hospital program which, although limited in its capacity, proved very successful. In the long-term the development of this type of program might be more promising for those other adolescents who are sent back to communities who have few or no resources and who consequently either ignore them or re-institutionalize them depending upon the degree of behavioral disturbance and community discomfort.

THE RELATIONSHIP OF MENTAL HEALTH AND EDUCATION

Lenore Behar, Ph.D.
Child Mental Health Services
Raleigh, N.C.

Waylon L. Bissette
Child Mental Health Services
Raleigh, N.C.

James L. Paul, Ed.D.
University of North Carolina
Chapel Hill, N.C.

In order to provide understanding of the education of emotionally disturbed children in the mental health system, the following areas are discussed: a) an historical and philosophical perspective of the development of educational services for emotionally disturbed children in the mental health system, including a brief fifteen year history of significant developments in this area which have led to changes in the definitions and in the roles of both the mental health and education systems; b) a brief description of the current status of needs; and c) a discussion of the unmet needs of children to provide a basis for the goals articulated.

HISTORICAL PERSPECTIVE - A GENERAL OVERVIEW

In *Action for Mental Health* (1960), the Final Report of the Joint Commission on Mental Illness and Health emphasized the problems of providing services for emotionally disturbed children. The general thrust of recommendations of the Commission, which had a mandate from Congress to survey resources and make recommendations for combating mental illness, was to develop more comprehensiveness and more services. During the fifteen years that have followed the Commission's Report, the ideas of continuity and comprehensiveness have continued to seem essential to the improvement of care of the emotionally disturbed child. In order to achieve these goals, the Commission emphasized the importance of a *part* of rather than a segregated system of services *apart from* other child support systems. While the Commission recommended fostering the development of psychiatric clinics to provide intensive psychotherapy for children, it recognized the larger potential of mental health clinics in the rehabilitation of children. "Ideally it (mental health clinic) should be considered a part of a spectrum of community services, including special instruction for classroom teachers in the handling of emotional disturbances, special public school classes for emotionally disturbed children, day care school centers, resident schools (not only for the around the clock patient, but also for day and/or night care), and children's units in general and mental hospitals." The report further suggests that in the absence of these resources, "make-shift arrangements" should use the counseling resources of the community which could include pediatricians interested in mental health, teachers, clergymen, county health nurses and social workers in departments of public welfare. The report recommended "pilot studies" to ascertain the feasibility of re-education centers for emotionally disturbed children using different types of personnel and operated by teachers backed up by mental health consultants. While some of these recommendations have been implemented, others have not. Clearly, they still have considerable conceptual and programmatic appeal.

In many ways, implementation of the Joint Commission's recommendations regarding the treatment of emotionally disturbed children has been impeded by major institutional, economic, philosophic, and scientific problems; there have been, however gradual, substantial changes in many areas, including the role of *educational services* for emotionally disturbed children during the past fifteen years. One significant aspect of that change has occurred in programming for children and youth first in psychiatric hospitals and later in community mental health centers. Part of the change has occurred as a result of changes in our *understanding of emotional disturbance*. Until the early sixties, the predominant view of emotional disturbance was that it was primarily an intrapsychic problem resulting mostly from an aberrant social history or unsuccessful primary relationships in early life. This explanation of emotional disturbance resulted in a limiting view of intervention, for it followed from this so-called "medical" view of the emotionally disturbed child as "sick" and that a cure-oriented treatment of psychotherapy was necessary. Other strategies were considered ancillary. Education was viewed more as an activity in school for "well" children who could cope with the requirements of the educational process. Psychiatric treatment, particularly hospitalization, became for many children a kind of "time-out" from real life work. Education for those children frequently was only resumed when the child was better able to cope, after psychiatric treatment had led to improved behavior.

More recently, there have been changes in the views of emotional disturbance in children and, consequently, changes in methods of treatment. Generally, five basic points of view have been developed including the psychodynamic, ecological, behavioral, sociological and biogenetic. These views have been helpful in expanding the scope and possibilities of intervention. For example, the behavioral perspective defines the problem more in terms of the child's having learned inappropriate or otherwise defeating behaviors and assumes that the child can be taught new and more satisfying behavior patterns. The ecological perspective offers a way of viewing the problem more in terms of the pattern of social exchange between the child and his family and his community environments, and suggests focusing on the interaction, rather than on the child alone, to develop an explanation of disturbance and related intervention strategies (Rhodes and Tracy, 1973, Rhodes and Head, 1974). Each view suggests rationale for intervention with an accompanying body of experimental and experiential literature.

One major consequence of the expanded view of emotional disturbance in children and of intervention possibilities has been the gradual re-examination of the roles of all aspects of the child's ecological system and particularly the role of the educational process in the treatment of the child. In a study of educational programming in psychiatric hospitals in North Carolina, (Ball et al, 1968) noted the need for "an explication of education as a therapeutic force." Education had formerly been accepted as an appropriate part of programming for children, however, without a clear definition of its role as a therapeutic force. The development of educational models whose goals are clearly defined, whose techniques are carefully described, and whose effects are evaluated would provide data about the potential of education in the hospital setting." (Ball et al, 1968).

It is significant to note the tone of tentativeness even in 1968, not unlike that in the Joint Commission's statement in 1960. Over the last fifteen years, since the Joint Commission Report, the mental health system has been slow to embrace educational approaches and the education system has been equally slow to be embraced. There are

many reasons for this, including the philosophical discontinuity between traditional mental health and traditional education concepts. A period of gestation has been required also in order for two large systems to find ways of connecting that did not excessively intrude into the territory of the other. Funding for educational services to handicapped children has facilitated the interdigitation of the two systems. Public Law 89-313 (ESEA Title I), for example, has both been evidence of the coming together and has made the development of educational services in mental health settings more feasible. Thus, given some practical reasons and some philosophical maturing in both quarters, progress has been made in fostering relationships between psychiatric hospitals/mental health clinics and public schools, both in the understanding of and treatment of children. Through this evolutionary process, education has provided the traditional mental health team an additional arena in which to understand the child's functioning and an additional resource for implementing rehabilitative strategies. *The education of the child has, at this point in time, become a significant component in the total habilitation program rather than, as formerly, a less integrated, less significant way of the child's "spending time" between therapy hours.*

There has, indeed, been convergence in both the conceptual and organizational areas of mental health and education. In addition to the recognition of the importance of educational programming in the rehabilitation of the child within the mental health system, therapeutic education and its teachers, are now becoming a major positive force in programming for emotionally disturbed children who remain in the public educational system. The issue of deviance in the schools has become a topic of major educational significance and has fostered improvements in curricula and the development of specialized methodologies. As the focus on the emotional development of children has increased, it is significant that the importance of alternative educational techniques, styles and environments has become recognized as important in responding to the needs, not only of handicapped children, but of all children.

Thus, mental health concepts and mental health personnel have become important in schools and in the educational process of "normal" children. For the child, rather than simply being a demanding system of behavioral and academic expectations, the educational process has become more actively a way to approach the development of social competencies. Teaching skills a child can use in more satisfactorily coping with the world enhances the child's opportunities to feel good about himself and influences his self concept, as well as his general view of this environment as a satisfying, rather than frustrating force. This new orientation toward teaching puts new energy into the exchange between the teacher and child, creates feelings of hope and motivation in the child, and facilitates growth in the interaction between the child and his environment.

Additionally, the negative aspects of what is happening in schools deserves more specific comment for it represents a source of concern to child mental health program development. Schools in most instances are still encapsulated units, separated from whole families and communities. School personnel and programs are, however, in many instances more actively involved with the whole child that comes to school—that is, his psychological, as well as his educational needs. It needs to be pointed out that while mental health programs have been increased in the schools and some of the mental health features of school environments have become better, other conditions have not changed or become worse. There are several reasons for this. Three general conditions which presently are influencing the development of mental health potential in the schools are: 1) the impact of mainstreaming; 2) the impact of desegregation; and

3) the impact of services to the preschool child. These areas of concern could be considered *new horizons* for the involvement of the mental health system.

One important influence has been the "mainstreaming" which brings into focus legal, psychological, social and educational issues. In the school environment, mainstreaming is accomplished by moving children from special classes into regular classes. The implications for the mainstreamed handicapped children are profound, as well as the implication for children in the already troubled waters of the mainstream. Mainstreaming also has important implications for the skills the regular classroom teacher will need to teach "all" the children.

Clearly, the mainstreaming movement has many potentially positive features for children; however, it does in fact reduce the educational alternatives for children in schools, and it does force many children into a "normal" environment which provides increased opportunity only for failure and frustration. Mainstreaming has serious implications for de-institutionalizing the residents of mental health institutions who may not be able to so rapidly move from a totally protected environment into the mainstream of public education, with all of its pressures and pitfalls.

At this point, "community education" and "coordination of services" takes on new meaning. The *mental health system must mainstream itself* in order to help make mainstreaming in public schools an appropriate alternative and the most frequently used alternative, when appropriate. The whole community and its "normalizing" and psychologically restorative potential must be recruited to help support the development of other types of positive, non-stigmatized options for children and their families when mainstreaming is not the best alternative for the child.

A second important influence has been through the very major social consequences of moving children around to accomplish an acceptable racial distribution of students, and the psychological by-products are enormous. Neighborhood peer groups are broken up. Old teacher-parent alliances are changed. Familiarity of place and people are at least initially lost. Fear and uncertainty about expectations in new environments are increased. Anxieties of parents over social issues are contagious and those have been shared with children. Schools are not "melting pots." They are, more than ever, centers of cultural diversity. Teachers frequently become anxious and overwhelmed by pluralism in values they find in their classrooms in addition to wide ranges of ability. They often become "hard" in order to defend their own uncertainties. Now "bus groups" are formed which have their own appeal and potential for good and ill for the children. They are, in many cases, decadent physical environments without any adult emotional support. Schools resonate the anger and fear of children, of teachers and of parents. The role of principals is especially difficult. Having to deal with chronic unrest and discipline problems without support, it is easy for them to develop the defensive habit of treating all children as guilty until proven innocent. Some urban schools have been referred to as "armed prison camps." Social problems have increased in the students, including alcohol and drug abuse. In the midst of situations described above are the weaker and more vulnerable handicapped children, many in special classes. Although handicapped children now have a "right to an education," schools can still deny the child the right to attend school if he cannot adapt to an acceptable student role. These are the children who need more support than the school can give them. They frequently end up in psychiatric institutions or in criminal institutions, depending on the rules they are first caught breaking. The provision of mental health support services, via the vehicle of "consultation and education" have made only small dents in these

mushrooming problems which have prevented the development of emotionally healthy environments for all children and of specialized environments for those with special needs.

Thirdly, the more recent focus on services to the pre-school child has led to a more natural alliance of mental health and preschool educational systems. Seemingly, this alliance has been accomplished because in fact in dealing with the child under six, it has not been so much a question of two distinct systems merging, but rather that of one system, including kindergarten, Headstart, day care, nursery schools, trying as a very young system to provide essential services to meeting the physical, emotional, and pre-educational development of the child. If one were to look for the single factor which historically contributed most to the development of a more comprehensive view of services to children, it might be introduction of Headstart as a bridge between many of the systems dealing with young children. The mandate of Headstart, followed by the Appalachian Regional Commission Program, was to provide all of the services thought necessary to maximize the child's developmental potential. The attempts to make such provisions, for young children, especially economically deprived children, made it rather clear that no single agency or single set of services could do the whole job. The somewhat abundant funds in these federal programs should, in most cases, decrease the tendencies towards interagency and intersystem competitiveness and territoriality, and encourage the collaboration necessary to deliver comprehensive services. The additional mandate that these programs serve a percentage of handicapped children increased the likelihood that supportive services would be important to the success of the programs.

Over the last five years, in the area of services to the preschool child, the development by the mental health centers of treatment programs for the behaviorally disturbed child has further fostered a conversion of preschool education services, mental health services and physical health services. Additional support for the convergence of systems has been gained through the United States Office of Education funding of programs under the Early Childhood Assistance Act (19) which provided impetus for the development of the remedial programs in the context of the preschool educational environment. Although over the years, therapeutic preschools had existed, there was lack in the treatment of children in hospital settings a de-emphasis of the importance of education; the preschool served essentially as an activity center and a baby sitting service between the treatment hours provided by the psychologists or psychiatrists. In the 1960's, however, those professionals interested in the preschool emotionally behaviorally disturbed child began to realize the importance of the preschool classroom as a vehicle for therapeutic intervention, rather than focusing on the single therapy hour, which seemed to have little effectiveness for a child of preschool age. Interestingly enough, at this point, there is a shared philosophy and relatively open communication system between all agencies that provide services to children of preschool age; the communication barriers still seem to exist, however, between this group, particularly those agencies such as health, social services, and mental health involved as support services, and those that provide educational services throughout the elementary school age children. As the effectiveness of service of these agencies increases, perhaps the elementary school system will become more amenable to input regarding "special" children from the preschool settings in support systems.

The professional advocacy systems, citizen groups and a re-orientation of professional focus all begin to contribute to the mental health system's increasing its

outreach in supporting decent, educative and restorative alternatives for all children. Part of the work can be in creative orchestration of mental health services with others, particularly with school systems as they develop increased therapeutic education and support services within the schools themselves. Another important part will have to be in identifying new ways of serving, both in improving the uses of existing services and in developing new approaches. The day hospital concept, the night hospital, group home living arrangements, year-round therapeutic camping, therapeutic foster care, big brother and big sister "buddy" and parent surrogate support arrangements, homemaker services, assisting and making better use of private resources, including privately operated foster care group homes, are examples of alternatives that exist between the polarities represented by mainstreaming at one extreme and institutional care/education at the other.

While in theory and in planning of mental health services, there have been some important innovations; the progress to date has been variable in the implementation of the kinds of innovations on a broad scale required to accomplish continuity in the delivery of services.

In some mental health centers, presently, only individual outpatient treatment is available. This has resulted in the misuse of hospital settings, with children who are not responsive to this one mode of treatment (individual therapy) being hospitalized because no intermediate kinds of treatment are available.

In other centers, however, there has been an increased emphasis on moving toward a comprehensive range of services for children and concurrently developing relationships with other child serving agencies for the purposes of mutual responsibilities for programs and for long range planning of integrated community services.

The recent focus on the need for intervention programs for preschool aged children has influenced mental health center directors, staff and the communities to address themselves to the needs of young children - therapy/parent education, day care consultation and psychoeducational day treatment programs for children. As these programs continue to develop, it seems likely that the demonstrated effectiveness of such programs for this age group, particularly psychoeducational day treatment, will encourage the development of adaptations for older children.

The development of group homes as a part of the mental health center programs has provided a special impetus toward a wider range of psychological and educational services.

Partly in conjunction with the group home thrust, a major move to de-institutionalize children from both training schools and mental hospitals has been developing, with the focus on moving them back into their home community as quickly as resources there can be adequately mobilized to support them. Advocacy for children has become an important thrust in service delivery, for it has helped to organize, inform, and enlist the support of parents, legislators, lawyers and any volunteers who are willing to share in helping the service delivery system become more comprehensive, providing a range of education and treatment services of increasing intensity for children.

The role of parents has changed from suspects in the scenario of the child's sickness, a role which served only to compound guilt and drain already limited reserves of energy, to allies in the process of helping the child toward a more healthy level of functioning. Parents have become advocates for services for their children.

Although, the beginnings have been slow, there is ample evidence that the changes are occurring and that through strong support and leadership at the federal, state, regional and local levels, resources are being made available to enable the positive thrusts of changes.

Needs

Educational programs within the mental health system that serve emotionally disturbed children occur in two types of settings, i.e., educational programs for children and residents in hospitals, therapeutic camps, and treatment centers; and educational programs that are a part of day treatment programs run by area mental health programs. There are special educational programs in all four state hospitals and Wright School, and there are plans for an educational program in the drug rehabilitation center at Black Mountain and at Camp Dolphin, but no plans for educational programs in the alcoholic rehabilitation centers. New program directions within the Division include Carolina Boys' Camp, Camp Dolphin and the therapeutic camp at Roanoke-Chowan, which have educational components. Within the group homes (21), including "Bringing It All Back Home," that are being developed in the mental health system, educational segments do or will exist; that is, supplementary educational programs for disturbed children who may only be able to stay part of the day in public school, or who cannot attend school at all.

Psychoeducational day programs for school age children are in operation in Johnston, Davidson, Chatham and Rutherford Counties. In all but Rutherford County, these day programs are special education units for the emotionally disturbed child, funded and staffed by the mental health center, but located in the public schools.

There has been, in the last two years, increasing focus on the mental health needs of preschool aged children, in a strong effort to provide early identification and early intervention services. Remedial programs follow a psychoeducational model, that is a therapeutic preschool approach, focusing both on the preschool educational and emotional needs of young children. Such educational day treatment programs, in conjunction with local area mental health centers, should be available within the next fiscal year in at least half of the area mental health programs, through a continuation of state and federal funding.

Although the needs are great to improve educational programs throughout the mental health system, in terms of priorities, we must provide first for those children for whom there are not other educational alternatives available; that is, those children who because of the seriousness of their emotional problems, must reside in state facilities. Some children, when they enter the facility, or as they progress toward a higher level of mental health, are capable of attending public schools; for these children efforts must be made in the local community for them to attend public school if and when they are ready. For the other children, who cannot attend public school, we must provide a full range of educational services, vocational training, which is relevant to their return to a normal educational environment, be it a public or private school, a technical training institute, or an institute of higher education; additionally, many children leave our institutions at an age when they choose to no longer continue formal education, and for these children we must use our educational programs to prepare them for employment and every day living.

In order to provide therapeutic/educational programs for seriously emotionally disturbed children, several points need to be considered. Because these children have intra-personal and developmental problems, as well as academic deficiencies, it is necessary for teachers to develop more intensive educational/intra-personal relationships with their students. Therefore, the teacher child ratio needs to be smaller than that in a classroom of normal children. More teachers are needed per population because of this ratio.

Because of the demands for individualized programming, as well as the above stated intensive relationship, highly qualified teachers must be hired. To accomplish this, the Division of Mental Health Services needs to provide teachers salaries that are at least equal to if not greater than the salaries provided by the local public school systems. It has been a constant problem that the Division of Mental Health Services, because of personnel classifications, has always had to pay teachers less, rather than more, than the local public schools, even though the job to be done takes greater skill and experience.

In addition to the actual demands on the teachers' time in direct educational activities, because of the other therapeutic services provided to children in the mental health programs, there are greater time demands made on the teachers to spend in integrated conferences so that the total program for the child may be a cohesive and coordinated one. However, one source of manpower are the university programs or the training of special education teachers. Expressed desire of the University of North Carolina, Special Education Consortium, which involves all of the campuses of the university system, to develop field based training programs for their students could provide our educational settings with increased manpower, as well as new ideas for program development and continued training of existing staff.

With no increase in state funds currently and a decrease in federal education funds, it is difficult to meet the demands necessary for increased quality of programs to existing staff. By this means, existing staff could improve skills and develop more efficient approaches to educating emotionally disturbed children.

In addition to the stated needs for increased manpower and better salaries, another way to improve the quality of programs is to provide inservice training. Teachers within the mental health system should be able to make use of training programs provided by mental health, as well as those provided by the Division of Public Instruction, for each of these types training programs meet different needs and provide different types of information. Many of the teachers in mental health have expressed the desire for more identification with members of their own profession, through this type of ongoing training.

At the community level, the most generally needed ingredient to better mental health/educational programming for children is joint sharing of responsibility and increased collaboration between the mental health clinics and the public school systems. Closely tied in to those networks of services should be the preschool centers in the community as well. A continuum of care for the normal child, as well as the exceptional child, could be developed with mental health serving as a back-up system. Through joint efforts with Pupil Personnel Services, the mental health center staff could provide support and inservice training in the area of the exceptional child for the normal classroom teacher. Additionally, on-site screening for the existence or the development of mental health problems in the classroom could be provided. Diagnostic services could be offered to augment the Pupil Personnel Services as needed. Collaborative planning for individualized programs in the classroom should follow. For those children needing resource rooms and/or special education classes, mental health center staff should work with the school system to obtain the resources necessary for such classrooms, seeking local, state, and federal support for such endeavors. Recognizing still that many children are at least for some period of time, could benefit more from removal from the public education system, special day centers in the community should be developed, either under the joint auspices of public education and mental health, or

through the mental health centers, with or without the help of other agencies. Although for the seriously impaired child, the mental health centers should be conceptualized as treatment centers, the importance of an education program should not be over-emphasized. For such impaired children, and especially those older adolescents who have clearly not made it with conventional education systems, other types of educational programs should be considered. These might include programs aimed toward vocational training or other educational programs relevant to every day living. The possibility of linkage with the community college system for older children should not be overlooked.

The development of day programs for children from preschool age through adolescents, is clearly an undeveloped area within the mental health system. Admittedly, expertise in the area of day treatment/education programs for emotionally disturbed children is hard to find and it has an important impact on the preschool training centers (schools of higher education preparing teachers) the need for such manpower.

The development of day treatment programs in the community would enable more children to receive specialized treatment without the need for residential care. At this point in time, many children are placed in residential care facilities because of their inability to succeed or even to exist comfortably within the public school systems; thus, many children have been placed in residential care because of the enormity of their difficulties (behavior and/or academic) in the public schools. Additionally, the creation of the development of such day programs in the community would also allow many children to be placed in less restrictive residential environments, decreasing the necessity for state hospital care. Placement in group homes and in foster care families, have for the most part, depending upon the child's ability to rather quickly move into the public education system, if not initially. Thus, the existence of specialized day/treatment/education programs would no doubt enable the placement of more children in these specialized environments. Additionally, mental health support for foster care families and foster care homes, such as those supported by private groups, would augment considerable resources available for the placement of exceptional children.

As more and more resources are developed in the community for the full day care treatment, and education of emotionally disturbed children, and as additional residential resources are developed, there should be a decrease in the use of the state hospitals as a resource for treating emotionally disturbed children. Eventual goal is to expand the specialty units somewhat, so that they may provide for all of the children in the state hospitals, with no children having to reside on adult wards. Until such time, however, these children who are on the adult wards, must be included in educational, vocational, and remedial education programs. At this point in time, there is a strong attempt to do this on the part of John Umstead and Broughton Hospitals, and Dorothea Dix Hospital has only this service available for all children in the hospital. However, these goals to provide educational programs for all children cannot be met because of the shortage of manpower and because of the problems of space and transportation of patients from one part of the hospital to another. These latter problems are, of course, lesser because of the manpower problems which could be created by expansion of staff, as well as to a closer tie in with the pre-service training institutions for the use of teachers in training. In addition to the in-house problems of the state hospitals in providing education as a part of the total treatment of children, there is the added

problem of liaison to public education system in returning children from the hospital environment to the community. Increased liaison staff is necessary either to relate directly to the child's school or to the local mental health center so that a staff member there can help the child make his way back into the public school. The latter approach seems more ideal, but is dependent upon the relationship between the mental health center and the school; eventually as these relationships become stronger, the liaison from the hospital should be to the mental health center. Thus, the mental health center can serve not only as the single portal of entry, but as the portal of exit for children as well.

GOALS

The goals stated in *Action for Mental Health* (1960), the final report of the Joint Commission on Mental Illness and Health are clearly still worthwhile goals and have not yet been fully attained. In developing programs for emotionally disturbed children, important steps have been taken towards continuity of care and comprehensiveness of service. However, there are important gaps in services, and there are very few communities that offer for all ages of children the continuity of mental health/education services recommended by the Joint Commission as stated later. In order to accomplish the expansion of services to provide 1) special support for classroom teachers in the handling of emotional disturbances; 2) special education classes for emotionally disturbed children; 3) day treatment/education centers; 4) residential/education centers and 5) comprehensive services for children in mental hospitals, several changes, to be discussed in more detail within. Perhaps the change most essential and most beneficial to the delivery of services for children, yet the one most difficult to accomplish, is a major shift in philosophy from programs designed to benefit special categories of children to those designed on a non-categorical basis.

It is becoming more and more clear that the development of programs to meet the special needs of special category children is an impractical approach to the delivery of mental health services. As mental health programs exist now, special categories of children are eligible for special types of services; but usually because of the funding agency's stipulations, the definition of categories of eligible children are clear cut. As a result, the multi-handicapped child, who may be for example, retarded and disturbed, is not eligible for any program designed to provide service to children with specific categories of need. Particularly the child defined as mildly impaired or borderline, in any of the categories seems to get shuffled back and forth between the programs, seemingly not having enough of any one handicap to make him eligible. Somewhat ironically, however, particularly in programs catering to younger children, many children are mis-diagnosed because of the complexity of their problem and the relative lack of sophistication in the area of diagnosis of very young children. As a result, many programs have developed, by this quirk, into non-categorical programs and find that in fact by individualized programming, the staff can provide adequately for the needs of other children in their care.

Throughout the country, there is a growing shift toward non-categorical programs, and in fact, within the Division of Public Instruction in North Carolina, such changes are gradually beginning. In order to eliminate intensive competition for funds, non-categorical programs are being developed with emphasis on individualized programming to meet the needs of the child's special needs. Particularly as mental health educational services for handicapped children are developed more fully in all of the

catchment areas across the State, the problems of small membership in special classes that exists now in small communities should be more apparent. Rather than having a preschool program for emotionally disturbed children and a preschool program for retarded children, neither of which are filled to capacity and both of which have to transport children for long distances, a more sensible approach seems to be to have two programs in different geographic areas, both serving both kinds of children.

Within the state hospitals, the educational programs that serve all of the child residents, especially those not on the specialty children's and youth units, find that they are dealing with a wide range of intellectual ability and serve many children who are either primarily retarded or at least functionally retarded by the incapacitating nature of their emotional problems.

Such a change in philosophy will be by necessity a gradual one, bringing into focus the needs of handicapped children, the administrative structure of the Division of Mental Health Services, and the special interests of citizens groups.

In order to attain the goals that the Joint Commission on Mental Illness and Health recommended regarding the interrelationship of mental health services and education services, expansion of existing programs and development of new programs are necessary. To reiterate the still unmet and still viable goals of the Commission, the report stated as follows:

"Ideally, it (Mental Health Services) should be considered a part of a spectrum of community services, including special instruction for classroom teachers in the handling of emotional disturbances, special public school classes for emotionally disturbed children, day care school centers, resident schools (not only for the around the clock patient, but also for day and/or night care), and children's units in general in mental hospitals."

The goals articulated by the Joint Commission on Mental Illness and Health were lofty ones indeed. It is hard to judge, at this point, whether or not the Commission felt that now, fifteen years later, these goals should be obtained or whether they too were aware of the enormous amount of time necessary to change both systems both philosophically and practically.

DIFFERENCES IN ATTITUDES ABOUT MENTAL ILLNESS AMONG STAFF IN AREA PROGRAMS AND UNITS OF A STATE PSYCHIATRIC HOSPITAL

**Stephen K. Creech, Ph.D.
Pitt County Mental Health Center
Greenville, North Carolina**

The literature (Canter, 1963; Carstairs, Heron, Levinson, & Pine, 1957; Ellsworth, 1965; Gilbert & Levinson, 1956; Lawton, 1964; Pine & Levinson, 1957) indicated that attitudes about mental illness held by mental health workers enter into the determination of many behaviors of the patients being served. This evidence strongly suggests that homogeneous attitudes about mental illness among mental health staff in units of a state psychiatric hospital and in area community mental health programs are positively related to treatment effectiveness.

Creech and Prewett (in press) used scales from both Cohen and Struening's (1962) *Opinions about Mental Illness (OMI)* questionnaire and Ellsworth's (1965) *Opinions about Mental Illness* questionnaire to study occupational groups from a state psychiatric hospital and five community mental health centers in North Carolina. The centers served a designated geographic area within the hospital's catchment area. The results demonstrated striking differences in attitudes toward the mentally ill (a) among occupational groups in both the state hospital and community centers, (b) between psychiatrists, psychologists, social workers, and nurses, and the psychiatric aides, (c) between hospital professionals and community mental health center professionals, and (d) between the total hospital sample and the total community mental health center sample.

The purpose of the present study was to further investigate the homogeneity of attitudes about mental illness as held by mental health personnel in the above state psychiatric hospital and community mental health centers. The study investigated staff attitudes across (1) hospital units, each serving patients from a designated geographic area in the region, and (2) community mental health centers, each serving a particular geographic area in the hospital's total catchment area. In addition, dyadic comparisons were made between the attitude scores of the employees of four geographic units in the hospital and the employees of the community mental health centers which serve patients admitted to the respective geographic units.

Method

The sample of this study consisted of 312 subjects, including 191 employees from six geographic units of a state psychiatric hospital and 121 employees from five community mental health centers. The community mental health centers were assigned code numbers for identification purposes, e.g., Center I, Center II, etc.; likewise, the units in the hospital were also assigned code numbers, e.g., Unit 3, Unit 4, etc. Such coding should help to preserve anonymity as well as to assist the reader in remembering that a specific community mental health center and geographic unit serve a particular patient population; for instance, Center III and Unit 3 both serve clients from the same geographic area. The reader will note in Table 2 that the first unit is designated as Unit 1-2 since that unit serves two area programs—Center I and II. No comparisons were made with the community counterparts of Units 6 and 7 since questionnaires were not returned by personnel of the two respective programs.

The subjects were anonymously administered the previously mentioned attitudinal questionnaire which yielded scores on eight attitudinal scales. Cohen and Struening's five scales, developed by factor analysis, are as follows:

A. **Authoritarianism.** This attitude indicates that mentally ill persons are perceived as threatening, inferior to normal persons, and requiring coercive handling.

B. **Benevolence.** The focus of this attitude is on a kindly paternalism whose origin lies in religion and humanism rather than science or the sophistication of professionalism.

C. **Mental Hygiene Ideology.** The historical position of the mental hygiene movement is represented by this attitude which emphasizes the virtues of charity, self-improvement, humanitarianism, and acceptance of the belief that mental illness can be treated successfully.

D. **Social Restrictiveness.** This attitude indicates a tendency to perceive the mental patient as a threat to society, particularly to the family unit, and in need of close restriction.

E. **Interpersonal Etiology.** This attitude indicates acceptance of the belief that mental illness results from certain kinds of interpersonal experiences, particularly deprivation of parental love early in life and in the influence of emotionally unstable parents in general.

Ellsworth empirically related endorsed attitudes of staff with the behavior of staff as perceived and rated by psychiatric patients. Ellsworth's three scales are Nontraditionalism, Restrictive Control and Protective Benevolence. Nontraditionalism, or Accountability, is an attitude dimension which indicates endorsement of warmth, sensitivity, understanding, openness, and honesty, and rejects such traditional concepts as the cause of mental illness is found in lack of will power, disease of the nervous system, and a lack of parental love. Restrictive Control was not included in this study because of previously determined high correlations ($r = +.91$) reported by Ellsworth (1965, p. 196) between Cohen and Struening's Social Restrictiveness and Restrictive Control. Protective Benevolence was also excluded here because of a lack of clear-cut findings related to the scale. The instrument used in the present study was composed of 64 six-point, Likert-type items ranging from strongly agree to strongly disagree. A high score on an attitudinal dimension represents endorsement of the attitude. The instrument contains a pool of statements concerning the cause, treatment, description, and prognosis of mental illness. Means on each of the scales for both hospital units and community mental health centers were subjected to a one-way analysis of variance. T-tests of the differences between mean scores of various group dyads were also calculated. Group means were then determined for raw scale scores and sten-transformed in order to compare groups' relative standings across the factors. Sten scores (Canfield, 1951) have a standardized one-digit score with a mean of 4.5 and a standard deviation of 2. Struening and Cohen's (1963) V.A. hospital standardization population provided the norms for the first five scales. Local norms were established for the present sample on the other dimension, Nontraditionalism.

Results

1. On Authoritarianism, mean differences in community mental health centers were statistically significant ($p = .005$), with Center II almost a standard deviation less than Center I. Centers I and II, highly different ($p = .001$) from each other, are both responsible for the area served by hospital geographic Unit 1-2. Further analysis by t-

tests showed that Unit 1-2 staff indicated only slightly higher endorsement ($p = .05$) of Authoritarianism than Center I staff, while the same unit personnel were much more authoritarian ($p = .001$) than Center II employees.

Only one other center-unit dyad serving a designated geographic area differed significantly on Authoritarianism. Subjects from Center III and Unit 3 differed sharply ($p = .001$) with the unit staff being much more authoritarian than the community center employees. No significant differences were found across employees of the six hospital units, as shown in Table 2.

2. On Benevolence, a small difference was found among the community mental health center employees, with Center II staff, who had the lowest mean on Authoritarianism, having the highest mean on Benevolence. On this scale, the staff of Center II barely differed ($p = .05$) from the staff of Unit 1-2, who were one sten score lower than their community counterparts. The greatest center-unit discrepancy on Benevolence was found between Center III and Unit 3 employees. Unlike the Center II-Unit 1-2 comparison, the differences here were reversed, with Unit 3 personnel being more benevolent ($p = .01$) than Center III respondents.

Highly significant differences were found among staff of the hospital units, with Unit 3 employees scoring more than one-and-one-half stens higher than the lowest mean, 3.1, of Unit 6. Benevolence was the only scale which showed statistically significant differences across the hospital subjects according to unit where employed.

3. On Mental Hygiene Ideology, no significant differences were detected in either the community or hospital samples. Comparisons of staff in community-unit dyads yielded only one significant difference, again between Center II and Unit 1-2 employees, with the unit indicating significantly ($p = .001$) less acceptance of the ideology than the community subjects.

4. On Social Restrictiveness, striking differences were found in the center subjects with Center II and Center V having the lowest means, as was the case on the Authoritarianism factor. No differences were found on Social Restrictiveness among the hospital units, but sharp attitudinal divergencies ($p = .001$), ($p = .005$) were found in employees of two center-unit dyads—Center II and Unit 1-2, and Center III and Unit 3. The unit personnel had the higher scores on Social Restrictiveness, like Authoritarianism, as noted earlier. The exceedingly low mean of Center II staff is especially noteworthy.

5. On Interpersonal Etiology, no differences were found in the hospital sample, community sample, or any dyadic community-unit comparison.

6. On Nontraditionalism, no significant differences were found among the unit subjects, although sharp differences were found across the center subjects. The mean, 6.6, of Center II staff members was more than a standard deviation higher than the mean, 4.5, of employees of Center I, a highly significant difference ($p = .001$). Center II personnel also differed greatly ($p = .001$) from their hospital staff counterparts in Unit 1-2. The regional dyad comprised of Unit 3 and Center III differed modestly, but still significantly ($p = .025$).

Discussion

The results of this investigation show that large differences in attitudes toward mental health patients existed across community mental health centers in a regional program, but that few differences existed across geographic units in a state psychiatric hospital. The centralizing demands found in large institutions like hospitals undoubtedly

contribute greatly toward uniform ideologies in staff. The findings also indicate that staff attitudes toward mental patients and mental illness were more homogeneous in some unit-center dyads than in others. Does this suggest that the unit-center dyads with the more homogeneous attitudes may be more successful in providing a continuity of patient care? No clear-cut trends were noted according to either size of the respective programs or proximity of the two types of mental health facilities. Until further research is conducted, one can only speculate that area mental health programs may be more effectively implemented where team members in both the hospital and community relate primarily to the general needs of the patient rather than to allegiance and adherence to the respective facility's ideology about mental illness and treatment. If a major goal in area programming is to establish the one-portal-of-entry concept, then it behooves area directors of community mental health centers, mental health institution administrators, and regional mental health coordinators to develop an integrated system of treatment, preventive and rehabilitative services through mental health workers of all disciplines.

Research (Cohen and Struening, 1964; Ellsworth, 1965; Kish, Solberg & Uecker, 1971; Meltzer & Smothers, 1967) indicates that employees' endorsed attitudes of Authoritarianism and Social Restrictiveness appear to be unfavorable, whereas endorsement of Benevolence, Mental Hygiene Ideology and Nontraditionalism seem favorable. Such evidence suggests that the profile of Center II employees is extremely favorable with its exceedingly low endorsement of Authoritarianism and Social Restrictiveness and very high endorsement of Benevolence, Mental Hygiene Ideology, and Nontraditionalism. Respondents from this center had the five most extreme scores in a favorable direction of all groups. An examination of the profile of employees from Center II reveals that the staff members do not perceive mentally ill persons as inferior persons who require coercive handling and restriction; instead, these employees' endorsed attitudes indicate that patients should be treated kindly, positively, and straightforwardly, including holding the patients accountable for their behavior.

Center I employees presented the highest authoritarian-restrictive-traditional profile of the community centers, yet still held a relatively favorable attitudinal profile when compared with the standardized population of Struening and Cohen (1963). Unquestionably, the larger percentage—approximately 75 per cent—of professional staff in Center II, compared to about 50 per cent in Center I, accounts for much of the variability of the two profiles. As indicated previously, Creech and Prewett (in press) reported that professionals tend to have more favorable attitudes toward the mentally ill than do nonprofessionals.

No further inferences should be drawn about comparative treatment effectiveness of the state hospital and community mental health centers since no information was obtained regarding the types of programs conducted in each facility, the situational demands of the particular treatment programs, or the amounts of time the staff and patients spent together during the patient's period of treatment. Nonetheless, one may wonder why employees of some unit-center dyads have homogeneous attitudes toward mental illness and mental patients, while employees of other area programs have heterogeneous attitudes. Since three of the five dyadic contrasts showed negligible differences, no clear-cut suggestions emerge regarding why the other two dyads should have had sharp divergencies in attitudes.

One cannot assume from the foregoing discussion that responses to a set of attitude statements toward mental illness represent a complete measure of the respondent's

attitude. However, Manis, Houts, and Blake (1963) point out that mentally ill persons are frequently responsive to staff attitudes, and the patients whose beliefs about mental illness are most strikingly influenced by the staff tend to respond most favorably to treatment. Furthermore, Evans and Bullard (1960) provide evidence of the importance of environmental factors upon discharged patients' level of adjustment and success in avoiding rehospitalization. Rosenhan's (1973) research points out that the sources of rehospitalization of mentally ill persons are found in (1) attitudes toward the mentally ill and (2) the hierarchical structure of the psychiatric facility, where those who are at the top have the least to do with patients.

Perhaps "misunderstandings" between personnel of regional mental health institutions and area programs frequently occur because of differences in attitudes about mental illness and mental patients, and discrepancies in views about what are mental health services. A unified approach to comprehensive mental health programs are provided in the various regions of the state. The training programs should be accompanied by research which utilizes common criteria of therapeutic effectiveness and program success, and indicates the amounts of influence which such variables as area boards, size of budgets, credentials of staff, and community resources have upon the optimum delivery of needed mental health services. Bold thrusts on treatment, training, and research are all needed if healthy living environments are to be established and maintained in the communities, and if positive therapeutic attitudinal atmospheres are to be created by mental health staff in the state hospitals and area programs.

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FACTORS INFLUENCING EMOTIONAL REACTIONS OF PARENTS OF DEVELOPMENTALLY HANDICAPPED CHILDREN

**Raymond Schmitt, M.D., Donald Routh, Ph.D., Elaine Goolsby, M.S.W.,
and Blan Minton, M.S.W.**

**Division for Disorders of Development and Learning
University of North Carolina at Chapel**

This study attempted to discover factors associated with worry and depressive affect among parents of children seen at a developmental evaluation facility. Certain factors in the background of the parents were taken into consideration as well as certain characteristics of the child, such as degree and type of handicap.

Emotional reactions by parents of mentally retarded and other handicapped children have long been studied. Farber (1959, 1960) for example identified two types of crisis in the families of severely retarded children, a 'bereavement' crisis and a crisis concerned with the difficulties of coping with the child's problems over an extended period of time. The bereavement crisis, which seems somewhat more relevant to the present study, was said by Farber to be precipitated at the time the child was diagnosed as retarded, often continuing for some time after this. Thus, according to Farber's view, one might expect to see chronic as well as acute depressive reactions by parents as a result of their discovery of their child's handicap.

The earlier writers about parental reactions (e.g., Kanner, 1953) often depended upon unstandardized clinical interviews in forming their conclusions. More recent work has typically adapted psychological tests and questionnaires originally developed for other purposes. Cummings, Bayles, and Rie (1966) for example, compared the mothers of mentally retarded children with mothers of healthy children, mothers of chronically ill children, and mothers of neurotic children on an attitude inventory, a questionnaire on child-rearing sentence-completion test, and other standard measures. They found that the mothers of retarded and of neurotic children showed more 'dysphoric affect' on three sentence-completion measures than did mothers of healthy or of chronically ill children.

However, research using standardized measures not specifically developed for the purpose has often led to negative results. Routh (1970) and Dee and Dee (1972) found that parents of retarded or of motor handicapped children seen in a child development clinic did not differ notably from parents of other, less handicapped children seen in the same clinic, in terms of their profiles on the Minnesota Multiphasic Personality Inventory. Thus, there is some question whether it is specifically the child's degree of handicap which is predictive of the parents' emotional reactions. The present study thus considered parent background factors in addition to factors describing the children, and used standard questions developed specifically for this purpose on the basis of extensive clinical experiences with the parents of children with developmental problems.

Method

Subjects

The subjects were the parents of a series of 28 consecutive children seen for evaluation of developmental or learning problems by a University Affiliated Facility for developmental disorders. In 18 of the families both parents were present for the

evaluation, but in eight cases only the mother was present and in two cases only the father, making a total of 46. The individual parent was regarded as the unit of analysis rather than the family. The 20 fathers who were interviewed initially ranged in age from 20 to 49 years, with a mean of 36 years. Their educational level ranged from 5th grade up to graduate professional training, the median education being a high school level. Four of the fathers were unskilled laborers; eight performed skilled labor or the equivalent, and eight were in managerial or professional positions. The 26 mothers interviewed initially ranged in age from 21 to 42 years, with a mean of 33 years. Their education ranged from 7th grade through college graduation, with high school education being the median. Seventeen of the mothers were not employed outside the home; of those who were employed, three did unskilled labor, three skilled labor or the equivalent, and three managerial or professional work.

The children being evaluated by the interdisciplinary team ranged in age from 9 months to 11 years, 2 months, with a mean of 5 years, 5 months. Eleven were girls and 17 were boys. In terms of level of mental ability, five of the children were found to be of at least average intelligence; eight were of borderline intellectual ability, seven mildly retarded, six moderately retarded, and two severely retarded as indicated by standard psychological evaluation (Bayley Mental Scale, Stanford-Binet Intelligence Scale, or Wechsler Intelligence Scale for Children). Six of the children were found to have physical handicaps such as cerebral palsy. Twenty-two had significant speech or language difficulties. Of the 28 children, three had only academic learning difficulties, unaccompanied by mental retardation, speech and language difficulties, or physical handicaps.

Procedure

Each parent was interviewed individually by a child psychiatrist or social worker. As part of a more extensive structured interview, the following 12 questions relating to emotional reactions on the part of the parent were included. A positive answer to each question received a score of 1 and a negative answer a score of 0, so that the total score could range from 0 to 12.

1. What is your estimate of how much of a burden (e.g., emotional) the child's situation has been to you so far? [Any admission of a burden was scored].
2. Because of the child's problems, have you experienced an increase in irritability?
3. Because of the child's problems, have you experienced an increase in worrisome thoughts about the child at work?
4. Because of the child's problems, have you experienced an increase in worrisome thoughts about the child interfering with sleep?
5. Because of the child's problems, have you experienced an increase in crying?
6. Because of the child's problems, have you experienced an increase in spells of sadness or depression?
7. Because of the child's problems, have you experienced an increase in feelings of hopelessness?
8. Because of the child's problems, have you experienced an increase in feelings of helplessness?
9. Because of the child's problems, have you experienced a loss of weight?
10. Because of the child's problems, have you experienced a loss of interest in work?
11. Because of the child's problems, have you experienced a loss of interest in sexual activity?

12. Because of the child's problems, have you experienced a loss of interest in a favorite passtime?

In addition to these questions, information was obtained on several possibly relevant background factors for each parent. Besides age, educational level, and occupation, each parent was asked whether he or she had any general health problems, had come from a broken home, and whether he or she or any relative had suffered from mental retardation, diagnosed mental illness, alcoholism, or a condition like that of the child currently being evaluated. It should be noted that none of the parents reported having a diagnosed mental illness, so it is difficult to relate this factor to the results of the study.

Of the 28 families in the initial series, 19 brought their children back for a return evaluation approximately one year after they were initially seen. It was thus possible to repeat the interview with the parents accompanying these children a second time, including the same 12 item reaction scale included as part of the initial interview. The questions were asked as before, qualified with the additional phrase 'during the past year.' For example a parent was asked how much of a burden the child or situation had been to him or her during the past year. Of the families who returned, it was possible to interview both parents again in eight cases, only the mother in another eight cases, and only the father in three cases. The families who came for the return evaluation tended to be those with somewhat younger children with greater likelihood of physical handicaps than those seen initially but were comparable in terms of degree of mental retardation and the incidence of speech and language problems.

During the course of the year all of the children had access to the services which had been recommended for them; and all of the parents had access to services or persons in a position to extend, at the least, emotional support and counseling regarding developmental management with their child.

Results

The mean number of items on the 12-item scale answered positively by parents upon initial evaluation was 3.98, with a range from 0 to 11. For the 27 parents evaluated both initially and at the one-year follow-up, the scores decreased from 3.96 to 2.67, a statistically significant change ($t=2.28$, $df=52$, $p=.05$). The correlation between initial and follow-up scores was also significant for this group ($r=.42$, $p=.05$).

Although the correlation between the scores of mothers and fathers in the same family was nonsignificant, the mothers as a group obtained significantly higher scores (mean, 4.94) than the fathers (mean, 3.05) at the initial evaluation ($t=2.13$, $df=34$, $p=.05$). The corresponding difference at one-year follow-up was nonsignificant.

None of the characteristics of the children which were investigated was significantly associated with the parents' initial or follow-up scores on the questionnaire, as evaluated by t-test or Pearson product-moment correlation coefficients. The characteristics assessed for possible association with the parents' scores included the child's age, presence or absence of a physical handicap, presence or absence of a speech problem, and degree of mental retardation.

Similarly, most of the background characteristics of the parents had no significant association with the initial or follow-up scores on the questionnaires, as assessed by t-test or Pearson correlation. These non-predictive factors included the parents' age, educational level, occupation, coming from a broken home, or having a family history of mental retardation, mental illness, or a condition like that of the child being evaluated. (No parent reported personal mental illness or mental retardation).

Parents who gave a family history of alcoholism, however, had a higher initial score (mean, 5.57) than those without such a history (mean, 3.28), a significant difference ($t=2.33$, $df=44$, $p=.05$). At the time of initial evaluation there were eight mothers who reported having alcoholic relatives in their families of origin and five fathers who reported alcoholism in their families of origin. Two mothers reported their own mothers to be alcoholic; another two reported their fathers to be alcoholic; one said her sister was alcoholic; another that a (biologic) aunt was such; another reported an alcoholic (biologic) uncle, and another a first cousin. One father reported his own father to be alcoholic; two fathers said they had an alcoholic brother; another said his grandfather was alcoholic; and another reported alcoholism on the part of a (biologic) uncle.

Upon follow-up one year later, 11 of the 13 parents returned who had initially given a family history of alcoholism. They continued to have a higher score on the questionnaire (mean, 4.38) than those without such a family history (mean, 1.95). The difference was still significant ($t=2.14$, $df=25$, $p=.05$).

Also, six parents (four mothers and two fathers) who reported problems with their general health tended to report a greater degree of emotional reaction upon initial evaluation (mean score, 7.12) than those without general health problems (mean score, 3.32), a significant difference ($t=2.81$, $df=44$, $p=.01$). At follow-up, however, the corresponding difference was non-significant.

Discussion

Many of these parents seemed to be worried or to have depressive effect, or both, at the time they brought their children in for the initial developmental evaluation. Those who were interviewed again a year later showed significantly lower scores than when first seen. These findings are generally consistent with Farber's (1960) description of a bereavement crisis in the parents of handicapped children. In this case the crisis was apparently precipitated by the knowledge or a growing awareness that there was something wrong with the child rather than by the formal diagnosis, since at the time of initial interview these parents had not learned the findings of the clinical team concerning their child. It seems possible that uncomfortable feelings were an important impetus which brought some families to the clinic in the first place.

As a group, the mothers expressed significantly more emotional reaction than the fathers. This may reflect, at least in part, the mothers' greater responsibility for the daily care of the children being evaluated. It was previously noted in describing the families that a majority of these women were full-time home makers, while all of the fathers were employed outside the home.

In this study no characteristic of the child which was investigated was found to be significantly associated with the extent of parental emotional reaction. This negative finding may be due to the lack of a control group of parents whose children are normal and who are not attending a developmental clinic. Other studies without such a control group (Dee & Dee, 1972; Routh, 1970) have also failed to find an association of severity of handicap in the child and parental emotional response. However, studies which have included parents of normal children, such as that of Cummings, Bayley, and Rie (1966) have indicated that handicap in the child is associated with depressive affect in the parent.

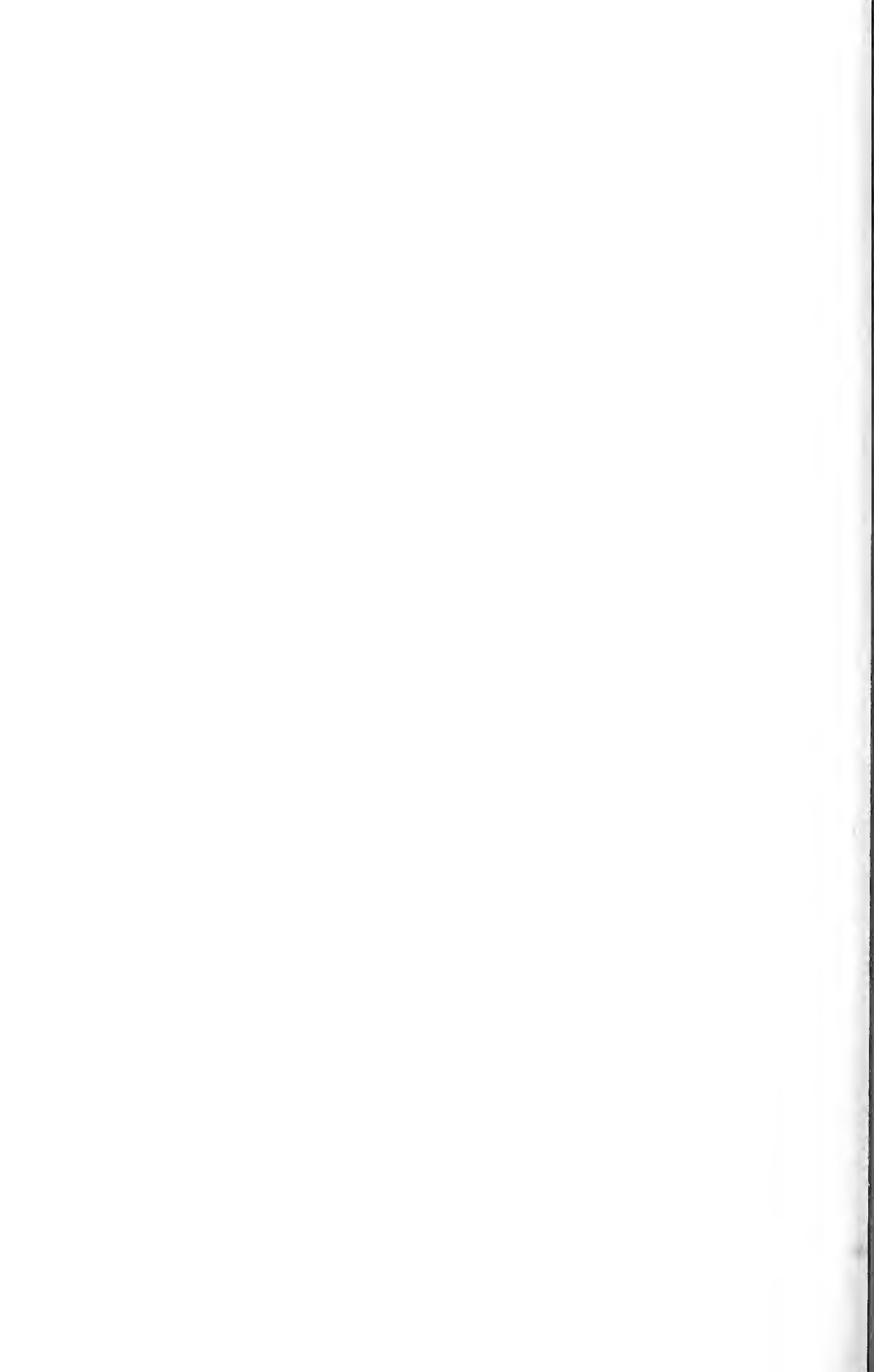
Poor general health was found to be associated with the extent of the emotional reactions initially seen in these parents. This is not surprising, since for example it appears that depressive affect can be a secondary symptomatic aspect of a number of

types of physical illness or an understandable response to the misfortune or limitation of function posed by health problems (Kline, 1969).

The most intriguing finding of the present study was that of an association between a family history of alcoholism and the extent of the emotional reaction in the parents of these handicapped children. Not only did the group of parents with an alcoholic relative tend to score more highly on the 12 item scale initially than other parents, but as a group their scores remained higher at the follow-up interview one year later. It is tempting to speculate on possible causes for this statistical association. The studies of Winokur (e.g., 1974) on families in which alcoholism is found in some members and a certain type of depressive problem is reported as affecting some other members provide one possible lead which might be investigated. There are, of course, other possible hypotheses.

One question which might be raised concerns the relationship of the two parent background predictors noted in this study. Statistical assessment did reveal that parents giving a family history of alcoholism also reported health problems more often than other parents (Fisher's exact Test, $p = .02$). This, however, was only true at the time of initial evaluation and not at the one year follow-up.

In summary, while the present study in itself is by no means conclusive, it does appear to provide useful leads for further and more detailed investigation into the important area of parental responses to a child's handicap.



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Manuscripts and editorial comments submitted for publication should be mailed to:

Drs. G. Tolley and T. Curtis
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N.C. Journal of Mental Health
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Manuscripts should be submitted in triplicate, double spaced, and total no more than 15 typewritten pages. The format of headings, tables, figures, citations, references, and other details should follow the style described in the *Publication Manual of the American Psychological Association*, available from the Association at 1200 Seventeenth Street, N.W., Washington, D.C. 20036. Tabular material, drawings and charts must be limited, due to publication costs, and should be submitted on separate sheets.

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EDITORIAL FOREWORD

The Editors wish to thank Dr. Maria Gispert and her colleagues for their tireless efforts to assemble and make more widely available the work of the authors appearing in this special issue of the Journal.

Their collective efforts constitute a substantial achievement from which each of us and those we seek to help will benefit.

We also wish to thank the publishers of those articles previously appearing elsewhere for their kind permission to reprint them in this collection. Each is noted individually within the text.

A. G. Tolley, M.D.
Thomas E. Curtis, M.D.
Editors-in-Chief



Editorial

The Committee on Women of the North Carolina Neuropsychiatric Association sponsored a section of the fall meeting program that took place in Asheville, North Carolina, October, 1975. Under the title of "Changing Images of Women", several papers were presented that elicited great interest in the audience. A request to publish them in the North Carolina Journal of Mental Health was expressed by one of the editors-in-chief of the Journal, Dr. Granville Tolley, in order to make the content available to all the members of the association who were not present at the meeting. We are very happy that after many vicissitudes we have been able to assemble and release for publication the papers mentioned and include others also relevant to this important and timely subject.

Until recently, the psychiatric literature has ignored or not taken seriously, issues and problems that concern women themselves. We are happy to contribute the present articles to the growing field of women's "studies." The areas discussed include the psychology of women, women under certain stressful circumstances such as medical school, psychiatric training and therapy and special health problems (abortion and rape). Knowing more about the causes of stress and their prevention, hopefully will help psychiatrists to be more effective in their efforts to enhance women's mental health.

Maria Gispert, M.D.
Guest Editor



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SPECIAL ISSUE ON WOMEN

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OVERVIEW: RESEARCH ON THE PSYCHOLOGY OF WOMEN_ I. GENDER DIFFERENCES AND SEXUAL AND REPRODUCTIVE LIFE*

Anne M. Seiden, M. D.
Institute for Juvenile Research
Chicago, Illinois

There has been a recent and rapid increase in research literature pertaining to women; this revolution in women's studies may be currently unequaled in any other field related to psychiatry. In this first part of a two-part article the author briefly discusses the social and intellectual contexts of research in this area. She reviews recent research on gender differences in behavior and on women's sexual and reproductive lives, including various aspects of the menstrual cycle, menopause, diseases of the reproductive organs, coitus, rape, childbirth, lactation, and fertility control. The second part will cover research on women in families, communities, work, and psychotherapy; and it will attempt to assess limitations of present knowledge and the anticipated directions and impact of future research.

That is all I had to say to you about femininity. It is certainly incomplete and fragmentary and does not always sound friendly. But do not forget that I have only been describing women in so far as their nature is determined by their sexual function. It is true that influence extends very far; but we do not overlook the fact that an individual woman may be a human being in other respects as well. If you want to know more about femininity, enquire from your own experiences of life, or turn to the poets, or wait until science can give you deeper and more coherent information. (p. 135)

—Sigmund Freud (1)

Research in the area that is now identified as "women's studies" has expanded exponentially over the past decade. Cutting across the social sciences, the humanities, and the biomedical sciences, the field of women's studies has characteristics of both an academic discipline and a social movement. This review will emphasize research within the fields of psychology and psychiatry and, to a certain extent, sociology and physiology. However, it is critical to note that much of the current research is being stimulated, conducted, funded, evaluated, and disseminated within the context of the broader interdisciplinary field of women's studies. The social and political, as well as the scientific, context of this field is important in both the production and the understanding of the research.

The recent knowledge explosion in women's studies is probably unequaled in any other discipline related to psychiatry. The term itself, "women's studies," was apparently first used about 1969 (2). In 1969 there were 2 university women's studies programs. By 1974, 900 institutions and 4,224 individuals were offering 4,658 courses in this area, with formal programs (one-third of them degree-granting) in 112 institutions (3, pp. vi-ix; 4). Nine volumes of synopses of women's studies courses have been published by KNOW, Inc. (5), and the Feminist Press (6). The latter maintains a clearinghouse on women's studies and publishes both a *Women's Studies Newsletter* and a guide to courses, programs, and teachers (3). Representative scholarly journals in this area include *Feminist Studies*, *Women's Studies*, *Sex Roles*, *Journal of the Psychology of Women*, *Journal of Women and Health*, and *Signs: Journal of Women in Culture and Society*. A number of standard professional journals, in or pertinent to the field of psychiatry, have recently included special issues or special sections on women's issues within their disciplines (7-12).

There has been sufficient publication in this area to justify the existence, since 1972, of

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two separate bibliographical periodicals, *Women's Studies Abstracts* and the *Canadian Newsletter of Research on Women* (which emphasizes non-U.S. sources). A number of annotated bibliographies have been published in specific areas related to women's issues, such as health, education, and mental health, including two research bibliographies from the National Institute of Mental Health (13, 14), one from the American Psychological Association (15), and a general one by Davis (16). Hochschild (17) reviewed the literature on sex roles and Long-Laws (18) the marital therapy literature, from a feminist perspective. In 1974 Eichler (19) published an annotated bibliography of bibliographies on women, and Astin and associates (20) added one on education and career issues. Daniels (21), commissioned by the Association of American Colleges' Project on the Status and Education of Women, surveyed existing research findings, persistent research questions, and sources for keeping up with this expanded flow of research.

In 1975 the *Annual Review of Psychology* for the first time included a section on the psychology of women (22). In contrast, Tennov (23) noted that of 35 introductory texts in social psychology published between 1940 and 1970, only 1 had a chapter concerning women.

More recently, several major texts on the psychology of women have appeared (24, 25), as well as several collections of readings suitable for textbook use (26-29). Earlier, but still classics, are Morgan's collection (30), which contains a number of important scientific as well as general articles, and Cade's collection of work on black women (31). Also important are several histories of the current women's movement (32), of male and female sex roles (33-35), and three archival collections of important historical documents (36-38). Two histories of childhood (39, 40) and one collection of archival sources on childhood (41) also contain historical research pertinent to women.

It is of interest that relatively little of this knowledge has thus far been directly incorporated into psychiatric teaching programs. In a 1973 survey, the American Psychiatric Association's Task Force on Women found that only 26 of the 167 residency programs responding offered course work in the psychology of women, sex roles, or related topics (less than the number offering courses dealing with ethnic minorities); most of these courses were elective rather than required (42). Major textbooks on psychiatry have not dealt extensively with the women's studies as such (although the current second editions of the books by Freedman and associates (43) and Arieti (44) are exceptions). While the 1974 examinations of the American Board of Psychiatry and Neurology and the APA's 1972 Psychiatric Knowledge and Skills Self-Assessment Program included a number of questions related to other social psychiatry issues, they did not examine in this area.

Clearly, the very newness of much of the work in this area accounts for its present relative absence from psychiatric curricula. Time is required for new research to be read, replicated, critically reviewed, and assimilated. When in addition the area in question is one that is as personally and professionally heavily loaded as this one, there may be some sources of caution or resistance that further delay the process. A psychiatrist's views of what women are or ought to be are rather obviously likely to have a more profound effect on one's personal life and world view than, for example, a double-blind study comparing the effects of two different neuroleptic agents. We bring our hopes and fears in this area to our design and evaluation of research results as surely as we do to our clinical work. Roeske's review of women in psychiatry (45) highlighted how often the psychiatric implications of gender issues have been handled by denial in clinical and training situations. That same denial may bias research by affecting the choice of research topics or subjects, the ways in which questions are asked, and the ways in which data are interpreted. Methodological problems are many and sometimes complex.

Nevertheless, there already exists a considerable body of new research that is of great importance to psychiatry. This overview will highlight major findings in selected aspects of this large area and will conclude with an assessment of the impact and limitations of the data and their present and future importance to psychiatry.¹

Research on Sex Differences

A vast amount of research has been conducted in an attempt to determine the nature and extent of sex differences. Much of this work has been carefully reviewed in a major book by Maccoby and Jacklin (48); their annotated bibliography cites approximately 1,500 studies appearing between 1966 and 1973 alone. Earlier studies in this area were reviewed by Maccoby (49), Sherman (24), Bardwick (25), and Garai and Scheinfeld (50). Clearly, the area of sex differences has attracted considerable research attention.

In principle, sex differences could arise from at least the following sources:

1. Intrinsic biological differences that are present from birth or a relatively early age.
2. Purely cultural differences in roles assigned to the sexes.
3. Anticipatory socialization, which is cultural at the time it is taught to the child but is preparatory for genuine biological differences that will not become apparent until a later age (e.g., childhood socialization for, or against, the adult experiences of childbirth and child nurture).
4. Differential value, meaning, or reward assigned by the culture to the gender-specific behaviors from sources 1, 2, and 3, causing certain types of behavior to be more strongly reinforced in a gender-specific way.

5. Further cultural elaboration of behaviors that predictably emerge as part of reactions to the more basic sources listed previously. For example, if women are differentially socialized against *direct* expression of sexuality or aggression, an elaborate secondary repertoire of *indirect* expression, sometimes called manipulation, is required.

Despite the theoretical importance of intrinsic biological differences and the considerable belief in them on a folk-wisdom basis, it is easier to demonstrate *belief* in these differences than the differences themselves. One study (51) found that fathers described their newborn daughters as "delicate" and their sons as "strong" before they had seen the children. Another study (52) found that mothers played differently with and observed different attributes in a strange child, depending on whether the child had been introduced as "Beth" or "Adam." While such beliefs can clearly become self-fulfilling prophecies, to what extent do they also rest on innate biological differences?

The difficulty is partly methodological; one cannot experimentally raise an otherwise normal human in a culture-free environment. But it is also substantive; the plasticity of human behavior is such that many biological differences can be overcome by learning. And the variability of human behavior is such that there is considerable overlap between the sexes on almost any variable chosen for comparison, with considerably more variation within than between the sexes.

Maccoby and Jacklin (48) summarized sex differences that they feel are fairly well established at this time. They are as follows:

1. Girls have, on the average, greater verbal ability than boys *after* about age 11, as measured by tasks involving both receptive and productive language. This is true for both "high-level" verbal tasks (e.g., analogies, comprehension of difficult written material, and creative writing) and "lower-level" ones (e.g., fluency).
2. Boys have, on the average, greater visual-spatial and mathematical ability beginning at about ages 12-13 and increasing through the high school years. There is some evidence that a recessive sex-linked gene contributes to greater than average spatial

ability in approximately 50% of all men and 25% of all women, which of course raises the average scores for males.

Both of these sex differences begin to emerge around the time of pubertal changes, but the evidence that biological factors are contributory is stronger for visual-spatial than verbal abilities. Sex differences in mathematical abilities vary greatly among populations, probably depending somewhat on the measures that are used (with mathematical problems involving spatial concepts giving an advantage to the greater number of boys with greater spatial abilities.).

3. Males are more "aggressive," with sex differences appearing as early as social play does (ages 2-2½) and appearing in both physical and verbal, direct and attenuated forms of aggression. The meaning of "aggression" is complex and will be discussed later.

Maccoby and Jacklin regarded the following as *unfounded* beliefs about sex differences: that girls are more socially oriented than boys, more suggestible, more auditory, less visual, less analytic but better at role learning, and lower in self-esteem and achievement motivation.

They regarded the following as areas open to question because of insufficient evidence or ambiguous findings: sex differences in tactile sensitivity, fear, timidity, anxiety, activity level, competitiveness, dominance, compliance, nurturance, and "maternal" (or parenting) behavior.

The activity-passivity dimension does not appear to differentiate the sexes unless one 1) confuses activity with aggression or 2) regards activity as masculine and passivity as feminine by definition, in which case the reasoning is circular. The confusion of activity with aggression arises in part because many measures of activity occur in situations that are also likely to arouse aggression.

If aggression is defined as "the intent of one individual to hurt another, either as such or as part of an attempt to control another for other ends (by use of fear)," it does persistently appear more commonly in males. This shows up cross-culturally and in different age ranges, although most of the studies Maccoby and Jacklin reviewed were laboratory studies done with young children. It was noted that mothers use more physical punishment (itself an aggressive act by this definition) with boys than girls, possibly setting up a circular process where aggression reinforces aggression. Where this process starts is uncertain, although Maccoby and Jacklin lean toward a biological explanation.

Maccoby and Jacklin (48, p. 371) suggested that a major effect of differences in aggressiveness on vocational choice may come about by default because "women, being slower to anger, are less likely to protest onerous assignments . . . to put the matter bluntly, they are easier to exploit" and therefore may accept less desirable vocational options.

Whatever the ultimate source, the present sex differences in aggression appear to be considerable, and there may be implications in this fact for social issues. Evidence from other sources (53, 54) indicates that some of the differences may be disappearing, with apparent increases in women of some forms of aggression, such as crimes of violence. It is possible that this kind of change, however much viewed with alarm, may have its positive aspects. The history of occupational sociology that as formerly male occupations become increasingly occupied by women (e.g., schoolteachers, bank tellers), they increasingly lose their attractiveness for men. It is in fantasy conceivable that the entry of larger numbers of adolescent and young adult women into the "field" of criminal violence might in part decrease its attractiveness as an arena for "proof" of masculinity.

With reference to child rearing, animal and cross-cultural work suggested to Maccoby and Jacklin that there may be some danger to children from untamed male aggression

but "that boys who have been involved in caring for younger siblings were less aggressive with age mates as well—i.e., . . . the process of caring for children at least on a part time basis can moderate aggressive tendencies" (48, p. 372). Discussing sex role traits, these authors made the obvious point that effectiveness as a husband and father can well be diminished by a machismo role, while "training a girl to be feminine" in the traditional nonassertive "helpless" and self-deprecatory sense may actually make her a worse mother. They concluded with the hopeful note that a society might "devote its energies more toward moderating male aggression, or toward encouraging rather than discouraging male nurturance activities" (p. 374), a conclusion also voiced by Eisenberg in a paper directed at pediatricians (55).

The generalizability of the work reviewed by Maccoby and Jacklin is significantly limited by the ages of the populations studied and the nature of behaviors observed. Guided by developmental theory, psychoanalytic or otherwise, the vast majority of the studies were done on children, often very young children; only a handful were done on adults. Yet the review shows that the most stable sex differences appear *after* puberty. In a recent review of current work in child development Baer and Wright (56) discussed the implications of reinforcement models (or social learning theory) as opposed to classical developmental models; the former imply relatively greater plasticity of behavior *if* the reinforcement conditions change, while the latter imply something close to the concept of "critical periods" for acquiring behaviors such as those which constitute sex differences.

Seiden I. Part 2

The rapidly expanding literature that explores the role of sex differences in the vicissitudes of achievement motivation essentially began with the work of Horner (57, 58). She did indeed find sex differences in late adolescents and adults, contrary to the findings for younger subjects summarized by Maccoby and Jacklin; it appears likely that reinforcement conditions of adolescent or adult life may account in large part for differences that apparently emerge after childhood. (Research on adult social roles will be further discussed in the second part of this overview.)

On the other hand, a now considerable body of clinical research on patients suffering from gender dysphorias, gender misdiagnoses, or gender changes intriguingly appears to require both developmental and reinforcement models. For example, the work of Money and Ehrhardt (59) and Stoller (60) suggests that there may be something like a critical period for the development of core gender identity (i.e., one's sense of "I am female" or "I am male"). Even when based on anatomical misdiagnosis that could be corrected, gender *identity* is presently found to be virtually irreversible after early childhood.

On the other hand, the content of gender *roles* (sex-typed behaviors) appears to be heavily based on social learning. Males who are reared as females or made to appear female can assume female role behavior convincingly enough to satisfy the average observer if certain conditions are met. These conditions ordinarily appear to include having a female gender identity fixed before a relatively critical age. The same is true for females reared as males, but it is of interest that the applications for male-to-female sex change far outnumber the applications for female-to-male change. It is not known to what extent this reflects the greater technical success of the male-to-female operation, the fact that female preponderance in child rearing makes male infants more likely to develop a female identification than are females to develop a male identification, or the possibility that the socially defined male gender role is in fact less stable, less biologically "given" and therefore "natural" and more "cultural" and ambiguous, thus more vulnerable to gender dysphoria (61).

Psychoanalytic developmental theory places heavy emphasis on the child's perception of sex and gender differences and the implications of traumatic awareness of these differences for later personality development. However, examination of female sexuality and personality is a particularly weak area in classical psychoanalytic theory, as noted by Freud (1) and Jones (62). A recent review by a noted psychoanalytic theoretician (63) concluded that "Freud's generalizations concerning girls and women do injustice to both his psychoanalytic method and his clinical findings," particularly in such essentials as equating femininity and passivity. It is of interest that in 1905 Freud published both "Three Essays on the Theory of Sexuality" (64) and the next to last case study of a woman to be included in the standard edition of his psychological work (65), although most of his case studies of men were published thereafter. In other words, his later and therefore presumably more mature theoretical thinking as applied to his own clinical work with women was not made available for review as published, detailed, clinical treatment studies.

Much of the earlier psychiatric thinking on gender differences and identification, particularly as subjectively experienced, derives from clinical psychoanalytic studies of adult patients. The methodological problems are obvious but are not easily solved. Adults may remember poorly, but small children verbalize poorly and adult observers may easily deny, distort, or exaggerate children's sexuality (as Freud (64) observed) or inaccurately project their own feelings and experience into their observations.

There is currently a keen psychoanalytic interest in gender difference issues in general, as well as female sexuality. There have been panels on aspects of female sexuality at virtually all of the recent psychoanalytic meetings. Unfortunately, most of this work lies outside the scope of this paper, since much of it is as yet unpublished and most of it is clinical or theoretical rather than research. An exception is the work of Roiphe and Galenson (66, 67). Based on observations of infants in nurseries and on parents' reports, they have demonstrated that awareness of gender differences regularly occurs by 18 months (much earlier than classical psychoanalytic theory postulated). In their samples this awareness did tend to be somewhat traumatic, but more than a transient difficulty in assimilating it appeared to be associated with prior experiences likely to have damaged object relations or the sense of bodily integrity (such as nongenital as well genital surgery).

Seiden I. part 3

Research on Sexual and Reproductive Life The Menstrual Cycle

Menarche probably marks a more clear-cut landmark in pubertal development than any single event in the adolescence of boys. The overwhelming majority of women of all ages can remember with precision the age and circumstances during which the first bleeding occurred. There is an enormous variation, of course, in the amount of intellectual understanding, anticipation, surprise, pain, affective change, and indeed the amount and regularity of bleeding that occurs with first periods. We are just beginning to get prospective data on samples of normal young women. One study (68) reported that some women have a sobering or even depressive response to first periods and begin to experience their lives as more serious or more restricted. Earlier studies (e.g., references 69-71) were based on retrospective data from adults but appear to provide general agreement.

Although menarche is a life event that could well be examined within the framework of crisis theory, and is marked by elaborate rituals in some primitive societies, our society pays relatively little public attention to it either ceremonially or in the scientific and general literature. Hygiene books for grade-school children generally omit references to

menstruation. Special booklets and films provided by manufacturers of sanitary products attempt to fill this gap, with some serious omissions noted by Whisnant and associates (72).

Somewhat more data are available on the biopsychological and behavioral effects of cyclicity as such (73-83). However, work in this area must be appraised with caution. The actual biological events are covered with considerable psychological and interpersonal overlay, and there are very real consequences in individuals' lives from the hasty acceptance of overgeneralized data. The fact that some women have severe premenstrual or menstrual incapacity and others do not has been used paradoxically both 1) to dismiss the seriousness or validity of the complaints of those who do have the syndrome, and 2) to assume erroneously that if some have it, all do. For example, one politically prominent physician was willing to officially state his belief that menstrual and menopausal syndromes made women as a group unfit for political office (84). By contrast, those women who do experience severe symptoms may have difficulty obtaining indicated medical treatment for this "psychogenic" malady (85).

Effects of the menstrual cycle. With these caveats in mind, what data are currently available about the effects of the menstrual cycle? A number of studies (73-76, 81-83) appear to show increases in certain affects (i.e., libido, irritability, anger, anxiety, and/or depression) in some women during the premenstrual and menstrual phases of the cycle and corresponding decreases in the same affects at other phases. This may be manifested in such diverse measures as self-reported affects, dream content, waking fantasies, and overt behaviors including increased accidents, committing violent crimes, and more frequently bringing one's children to emergency rooms for minor illnesses. Some studies show increased and some decreased libido (73, 74).

The proportion of women reporting any of these effects varies among studies but averages about 50% (this average is undoubtedly somewhat inflated by the fact that studies showing negative effects are less likely to be published). In one series of prospective studies (75, 76), women who on entering college reported severe menstrual distress turned out to have lower grade-point averages and a greater probability of diagnosis of affective disorder, suggesting the possibility that bipolar affective disorder in women may initially present as menstrual distress. However, in a nonclinical population Sommer (77) failed to find any evidence of intellectual or performance changes with the cycle.

Methodological problems in this area are many. It is obvious that a woman's own expectations about menstruation (and possibly those of her family, friends, or sexual partners) could override purely hormonal factors. Indeed, Paige (78) found that reported menstrual distress varied with both the subject's religion and the actual amount of bleeding (itself dependent on hormonal manipulation). Koeske (79) showed that vignettes describing angry behavior by women were attributed by college student judges to environmental events unless the vignette included the information that the subject was in a premenstrual or menstrual phase, in which case the same behavior was attributed to menstrual-related tension. Parlee (80) has reexamined Dalton's data (74) showing poorer examination performance by menstruating students. The same data also provided evidence for delayed menstruation in a portion of the sample. Cycle variability is considerable, and stress can delay or accelerate ovulation and menstruation. Therefore it is possible that prolonged stressful situations, culminating in attempted suicide, violent crimes, or poor examination performance, and then a period, could sometimes represent "tension-delayed menstruation" instead of "premenstrual tension" (80).

Surprisingly, after all these centuries of human menstruation, we still do not have definitive data on the subject. It is intriguing, however, as Parlee (81) noted, that most

researchers attribute behavioral or affective changes associated with the menstrual cycle to hormonal factors, but are more likely to attribute emotional changes during pregnancy to the woman's life situation of intrapsychic conflicts about motherhood, despite the fact that there are considerable greater hormonal changes associated with pregnancy.

More research in this area is clearly needed. At the present, reviews by Parlee (81), Melges and Hamburg (82), and Dalton (74), and Weideger's book for general readers (83) seem to provide the best coverage of the topic.

Effects of other types of cyclicity. While the greater visibility of cyclical changes in menstruating women has attracted more study, researchers are beginning to study the effects of cyclicity in hysterectomized women who retain their ovaries and in men (86, 87). Testosterone levels in men do vary with time, with access to sexual opportunities, and apparently on occasion with the menstrual cycle of the usual sexual partner. In rhesus monkeys, testosterone levels can be experimentally manipulated by artificially changing the male's access to estrous females or his dominance position vis-a-vis other males (88). Other studies of women have shown greater affective and behavioral fluctuation with the weekly cycle (work week versus weekends) than with the menstrual cycle (e.g., reference 89); diurnal cycles are important in affecting hormonal and affective changes in men and women. The whole topic will be more comprehensively dealt with when it can be brought together with the growing literature on circadian and ultradian rhythms in general.

Menopause

Menopause is a distinctly human characteristic. In most other mammals, the sexes do not differ greatly in their capacity for maintaining fertility up to advanced old age. The biological adaptive value would appear to be related to other distinctive human characteristics such as the prolonged period of childhood dependency, with complex care-taking behaviors that in the human are not fixed action patterns but must be learned. The existence of menopause assures that an average healthy woman will have many years of vigor and good health following the birth of her youngest child. This freedom from new pregnancies permits more extended child rearing as well as participation in a number of teaching, care-taking, and leadership functions. Selective pressures clearly appear to have favored those of our ancestors whose females had menopause over those who did not. Thus it is particularly ironic that the medical and psychiatric literature on menopause, as reviewed by Osofsky and Seidenberg (90), tends to view it as "a time of mortification, with service to the species over."

Symptoms of menopause. Symptoms attributed to the menopausal phase itself include vasomotor instability (hot flashes, night sweats) and emotional difficulties (irritability, anxiety, depression, insomnia, etc.). Symptoms attributed to the postmenopausal phase have included estrogen deficiency syndromes (vaginal mucosal thinning) and emotional difficulties, predominantly depression, with impaired self-esteem. Interestingly, we do not have generalizable data on the prevalence of these symptoms in the population at risk. One review (91) suggested that the vasomotor symptoms are more frequent in women of menopausal age than other ages, but emotional symptoms are not.

As with menstrual symptoms, there has been a paradoxical tendency to assume that if some women have severe or troublesome symptoms, all must, and conversely, to either provide inadequate treatment for the presumed "psychogenic" symptoms of those who do or prescribe unnecessary (and apparently carcinogenic) (92) estrogens even when symptoms are mild or unrelated to estrogen deficiency.

Thus far there appears to be a relative neglect of the effects of the menopause (and its anticipation) in much of the recent work on psychology of women. A number of relatively

comprehensive books on women (e.g., reference 24) and sex differences (28, 48, 59, 93) do not deal with it at all, despite the fact that the relatively early end of female versus male fertility is one of the more striking sex differences in humans.

Social factors. Standard texts do not appear to include many references to cross-cultural work bearing on the important question of the extent to which menopausal symptoms are prominent in cultures in which women's social power and influence rise rather than decline with age. In any society menopausal phenomena are inevitably intertwined with other aspects of beginning middle age. Women are more likely to be widowed than are men, and if this occurs they have less chance of remarriage, a salient difference in a social structure primarily organized around the heterosexual pair bond. At about the same time as the menopausal years, many women are dealing simultaneously with the departure of children from the home, the entry of the husband (who is likely to be several years older) into the years of preretirement, and the risk of middle-age depression and even death. These factors merit study in relation to the emotional difficulties reported by some women at these ages. Social factors seem to be at least as important as biological ones at this point. For example, the factors predictive of an active sexual life in older age groups have emerged as general good health, prior active sex life, and the availability of an interested and interesting partner (94).

Diseases of the Reproductive Organs

An aspect of body image with an important effect on the psychology of both sexes is the potential for life-threatening or life-disrupting diseases of the reproductive organs, particularly when those diseases are mysterious or related to sexual activity or both. Thus syphilophobia was apparently a far more common clinical entity when the natural history of syphilis was less well understood and its treatment less effective than they are today.

The internal position of most of the genital organs in women is generally believed to contribute to women's sexuality being perceived as more mysterious by both women and men; but for women this poses a body image problem as well. If the organs cannot be seen, their very existence and certainly their healthy functioning cannot be verified except by inference; Barnett (95) found evidence of a body-image scotoma in girls including the vagina itself and the organs within, and Whisnant and associates (72) found that adolescent girls still had extremely vague notions of just what was supposed to be where, even after receiving instruction on the subject.

Yet women who have received reasonably adequate health education (and women's magazines contain a great deal more of this than men's do) have been told of the risks of having cervical and uterine cancer and asymptomatic venereal infections: these risky conditions can only be detected by having someone else examine the woman's body and do appropriate tests. While the woman is assured that she should examine her own breasts for lumps, she is reminded that only a physician can tell if they are benign. Thus her appropriate health education, if carried out well, must inform her of the risk that these parts of her body can, as it were, turn against her in a malignant way. Whereas in past years a woman's potential fear that her own body might kill her may have been more closely associated with a fear of obstetrical catastrophes, in contemporary life the risk of death from breast or genital cancer is relatively much greater.

Like so much about women's biology, these risks are currently both overreacted to and underreacted to. That they nevertheless play an important role in women's psychology seems likely. It is quite possible that a vaguely defined fear of death or disease from genital organs has contributed to women's willingness to undergo hysterectomies far more often than is generally believed necessary. Indeed, the word itself may favor such treatment;

excessive concern with ill-defined body complaints is more likely to be called "hysteria" in women, whereas comparable symptoms in men are more likely to be called "hypochondriasis" (referring literally to chest pain). On the other hand, the average adult patient visiting any physician's office with almost any complaint is likely to have the heart and lungs examined (thus detecting evidence of the prime killers of middle-aged men), while the average woman, unless coming with specific complaints related to these systems, is much less likely to receive thorough breast and pelvic examinations (which might detect the prime killers of middle-aged women).

There do not seem to have been any studies of the actual prevalence of fears of one's own body among nonclinical populations of women and men. Such studies would be difficult, if one postulates that displacement of such fears onto symptoms such as backache occurs to an unknown degree. However, there have been a moderate number of studies in recent years on the psychological effects of breast and genital surgery on women (e.g., 96). Most of them have dealt with the effects of surgery for malignancies and thus do not add to our knowledge of the effects of loss of specifically female body parts per se, apart from the frequently associated fear of death from malignancy.

Seiden I. part 4

Coitus

The psychology of coital behavior has recently received more clinical and research attention than many other aspects of female psychology. Much of the current thinking and research in this area appears to be a rediscovery of knowledge that was temporarily lost. Late Victorian medical and popular writers have been quoted as believing that "normal" women do not enjoy sexual intercourse, but early Victorian and earlier writers did not share this belief (97). Clitoral anatomy and orgasm were accurately described by early Victorian medical writers (98), who also advocated early marriage, since they believed that women's sexual needs were very strong and if denied might lead to hysteria or other untoward consequences.

Late Victorian and even recent medical writers have tended to define healthy female sexuality primarily in terms of its adaptiveness to male sexual needs (8, 97, 99). Indeed, a fairly recent review of the discussion of female sexuality in gynecology textbooks (8, pp. 283-288) uncovered such remarkable statements as "if a woman after a year of marriage is not able to adapt her sexual needs to those of her husband, medical attention is indicated." The clitoral-vaginal orgasm pseudocontroversy appears to be an example of the same thing. Masters and Johnson (100) have described the physiology of female orgasm, as did Kinsey and associates (101) and early Victorian writers (98).

Clitoral or vaginal stimulation (and occasionally fantasy or breast stimulation) can all evoke orgasm; there are differences in stimulation but not in the physiology of the orgasm itself. Women may subjectively experience clear differences between "little" orgasms (more accurately, relaxation from peak excitement without orgasm proper, which is perhaps analogous to satisfactory intercourse without ejaculation, as is common in older men) and "big" orgasm (or orgasm proper, accompanied by spasm of the pubococcygeal muscles). This spasm is perceived vaginally if it is differentiated from the total experience, regardless of whether the evoking stimulation was clitoral or vaginal (102). The spasms be more intense with clitoral stimulation (100), but it may be more consciously perceived if vaginal stimulation focuses attention on that area. The psychological difference between clitoral and vaginal stimulation clearly has much to do with the fact that an adequate male partner is more often associated with the latter. Whatever the locus of the tac-

tile stimulation, the interpersonal and fantasy aspects of the situation heavily color the woman's subjective experience.

Freud (1) believed that lesser "maturity" was likely to be associated with a preference for clitoral stimulation. In those cases where this is true, such preference might rest on the fact that a woman may need greater maturity and skill in order to effectively communicate her sexual needs to a male partner than to fill them herself. Indeed, contemporary sex therapy approaches as reviewed, for example, by Kaplan (103), tend to emphasize helping both partners to communicate their sensual and sexual feelings and encouraging conditions that are favorable for evoking female orgasm in coitus (such as adequate foreplay, freedom to use the female superior position, an unhurried atmosphere, deconditioning of premature ejaculation, and verbal and nonverbal communication).

There are some interesting differences in the kinds of sex therapy that have been advocated for the two sexes. While most sex therapists today feel strongly that the best results are obtained from working conjointly with a committed couple, it seemed natural to Masters and Johnson to provide surrogate partners for men who lacked a partner willing to participate (104). Medicolegal problems, rather than purely therapeutic ones, forced the abandonment of this program. On the other hand, approaches directed at treating the preorgasmic woman without a participant partner have tended to emphasize a method of teaching her to masturbate to orgasm by means of deconditioning, "permission-giving," sensory awareness, and encouragement (102, 105). The rationale here is to increase her sexual activity and autonomy; she can hardly be expected to communicate her sexual needs and wishes to a partner if she does not know them from her own experience, and she cannot easily be sexually effective if she believes female sexuality to be a passive experience. The fact that most studies have shown that far fewer women than men spontaneously masturbate during adolescence (e.g., reference 101) appears to be consistent with the need for this approach. It is interesting to note that women who go on to high intellectual achievement are more likely to have had active masturbatory lives in adolescence (106).

Sexual dysfunction is said to be extremely common among American couples; Masters and Johnson (104) estimated that up to 50% of all couples are sexually dysfunctional. While no recent and representative large-scale surveys seem to bear directly on this point, it appears that sexual difficulties are common among college populations and that students seeking help at college mental health services do not necessarily voice their difficulties in this area unless they are specifically asked about it (107).

Rape

Forced coitus, that is, rape, is a distinctively human capacity. The recent increase in awareness of psychological consequences of rape or fear of rape has led to a rapidly developing area of psychiatric, sociological and legal research, recently reviewed by Hilberman (108). Much of the work is clinical and is directed at recommending or evaluating treatment approaches to rape victims or studying psychological characteristics of convicted rapists or known victims. The low rates of reporting rape and seeking treatment, and the even lower rates of conviction, have seriously hampered research in this area. Self-report studies suffer from one kind of sampling bias, but emergency room or prison studies suffer from another. It has therefore been impossible thus far to obtain representative samples of rapists or victims, but a few tentative conclusions can be drawn from available research.

Enduring psychological distress attributed to being raped is not uncommon (109, 110). The insensitive behavior of police and hospital personnel has often been contributory, to the extent that women feel raped a second time. Women have often been victimized rather than protected by attempts at conviction (e.g., court proceedings damaging her reputation, while the defendant's is not admissible as evidence) or prevention (e.g., suggestions that women should stay in at night, thus limiting their vocational and social options). Yet male concern over the possibility of false accusation runs high. In one sample (111), psychiatric treatment for victims had been more often provided and more often perceived as helpful when the victim was a child rather than an adult at the time of the attack. This may have been due in part to the fact that attempts at treatment of adult victims have often focused, like so much in psychotherapy, on the hope of finding a remediable way in which the victim contributed to her own victimization—inadvertently adding to her victimization by blaming her.

The possibility of being raped also affects the psychology of women who have *not* been raped to an as yet unidentified extent. Beginning with early childhood, families provide more chaperonage for daughters than sons (112). Women in cities are more fearful of going out at night than men are. The presumed effects of *fear* of rape are to heighten dependency on men as protectors, yet reported effects of an actual rape are both an increased fear of another rape and, frequently, a wish to avoid men altogether. We do not know at present the extent to which long-lasting post-rape trauma is intrinsic versus iatrogenic, that is, a result of traumatic or inadequate treatment of the victim. Fortunately, there appears to be considerable interest in improving treatment approaches, and a monograph on rape victims and their treatment has recently been published by the American Psychiatric Association (108).

Childbirth

Childbirth among humans appears to be more variable, more subject to learning, and less "instinctive" than in other animals. Even something as basic as labor pain is enormously variable in amount and characteristics, subject not only to strictly physical variables such as size and position of the infant and the like, but also to prior learning, personal and cultural expectations, obstetrical procedures, and other variables not yet clearly delineated. Until recently, obstetrical catastrophes including postpartum infection were relatively common, and fear of birth was held to be a realistic part of human experience. Thus the parents and social milieu of many of today's mothers may have transmitted a psychology of fear, pain, fatalism, and the like. General taboos on sex education have extended to the subject of childbirth, so that young women are likely to form attitudes about birth many years before accurate information about it is available to them.

Unquestionably, modern medicine and obstetrics have made major and life-saving advances. Maternal and neonatal mortality rates have decreased considerably. This is widely attributed to the "medicalization" of childbirth and use of the hospital for deliveries, although American statistics continue to be less favorable than those of other countries, such as Holland, which use hospital obstetrics more selectively for high-risk births (113). Even in this country the hospital birth is relatively new. A majority of all births occurred at home as recently as 1938, less than two generations ago (114).

At present, a high proportion of maternal deaths and infant complications in America results from anesthesia (115). The need for relief of pain during normal delivery is so intimately bound up with the mother's expectations and training, and the effects of maternal and infant sedation so closely related to formation of the mother-child bond, that

management of obstetrical pain and anxiety must be considered a pediatric and psychiatric research area as well as an obstetrical one. Fairly recently, observers within obstetrics, pediatrics, and some consumer groups have scrutinized psychosocial aspects of current obstetrical practices (113, 114, 116, 117), and national and international societies for psychosomatic obstetrics and gynecology have been formed.

Adverse effects of medical procedures. Research (117) has demonstrated the adverse effects of medication on length of labor and infants' arousal level and sucking behavior sometimes persisting as long as four to seven days). Aspects of hospital milieu and practice, such as unfamiliar environment, presence of strangers, and being moved from one room to another late in labor, have been shown to adversely affect labor in human and inhuman species (118). The common practice of separating the mother and infant immediately after birth, and maintaining a separation of at least several days punctuated by brief feeding periods, appears to adversely affect the formation of a mother-child bond (119). It is possible that the total exclusion of husband and siblings from contact with the child during the days immediately after birth, coupled with separation from the mother, may adversely affect these other family bonds as well.

The issues here are rather like those involved in the classic studies of hospitalism in infants and children (e.g., reference 120). Procedures undertaken for sound medical rationale, such as provision of treatment and prevention of spread of infection, were shown to be sufficiently disruptive to normal psychological processes that their overall value had to be questioned. The point here is not that these procedures (or some of them) are not often important for the treatment of complications, but that until fairly recently there has been a surprising neglect for the possible profound psychological implications of these procedures and the implication that they are *always* necessary, rather than a standardization of what is *sometimes* necessary.

Indeed, most of the psychiatric studies of adverse psychological responses to the childbirth situation have concentrated on preexisting pathology in the mother (which may, of course, exist) to the exclusion of the effects of the birth situation or the anticipated child-rearing situation (81). I have been unable to locate any outcome study examining the effects of preexisting maternal psychopathology *in interaction with* adverse effects of the birth situation, although it seems highly likely that a woman who is psychologically healthy, and anticipating a wanted child, might be better able to tolerate the customary degrees of psychological interference during the birth process than a less favorably situated woman.

Procedural modifications. Social and consumer movements developing around childbirth and lactation, such as the LaMaze and LaLeche groups (121), have attempted to counter some of these trends, but at times they have also tended to further compromise the mother's sense of mastery (122). For example, contemporary attempts to save what is best in both modern obstetrical practices and more "natural" methods have primarily addressed themselves to the married couple (e.g., reference 123). Yet one-third of the first-born children in America are conceived outside of marriage (124). While about half of these conceptions are legitimated by marriage, many of the marriages are unstable. Thus the current emphasis on participation by the husband may not offer psychological help to the woman who probably needs it most. It would appear, for example, that an unmarried adolescent mother whose family is ambivalent about or opposed to the birth would have an especially great need for any modification of obstetrical procedures that could enhance her own sense of mastery and adulthood and enhance the mother-child bonding process.

Lactation

Mead and Newton (125) have called lactation a transitional period in the mother-child relationship, the time between birth and weaning from the breast. They noted that in primitive cultures this period may last for years but that in modern America it may be non-existent. Goodall (126) has noted that in chimpanzees it may last four or five years, thus for this species almost until puberty. Prolonged lactation may be seen as incompatible with the demands of industrial society or simply as too sensual for public indulgence, and it may also be seen as a threat to the marital bond or as an obstruction to shared parenting. The usual American practice is to omit it altogether (most common) or attenuate it with early introduction of solid foods and supplementary bottles.

There are several immediate postpartum physiological advantages of breast feeding. The mother gains the benefits of nipple stimulation with consequent prolactin release and a more rapid uterine involution, and the infant obtains colostrum, which contains valuable antibodies (127). The psychological aspect of breast feeding tends to be either romanticized or neglected; to me it significantly includes fostering a mutual rather than an altruistic beginning of the mother-child relationship. A nursing mother is likely to experience milk let-down at the time the baby cries from hunger; the nursing experience both relieves and indulges the mother and child. Thus from the beginning each is providing comfort to the other. In contrast, bottle feeding is primarily for the baby's sake and provides much less libidinal satisfaction to the mother. It is clearly possible to raise children this way, particularly when they are very much wanted, but current statistics on child abuse suggest that in many cases reliance on altruism for the establishment of the mother-child bond is hazardous (128).

Fertility Control

It is generally believed that safe, reliable, available contraception and abortion are new and are effecting profound changes in the psychology of reproductive life for women. This is both true and not true. Methods of contraception and abortion have been available since antiquity, partially suppressed at times because of religious or moral beliefs, population needs, or concerns about safety or efficacy. In the United States abortion on request and the dissemination of contraceptive and abortifacient knowledge and devices were legal until 1872, when the Comstock laws were passed. Legislative and judicial repeals of barriers to these services have been recent and have been accompanied by advances in both contraceptive knowledge and its dissemination.

Thus, for many women today, the norm of controlling one's own fertility is experienced as relatively new. It follows that there is a cultural lag in assimilating these expectations. Pregnancy is now generally felt to be a matter of choice (whether conscious or unconscious) rather than fate, despite the fact that no temporary method is 100% effective. Thus the expectation of control of conception outstrips the reality. The corollary of increased choice appears to be an enhanced sense of responsibility for the outcome of childbearing, with vulnerability to guilt and other feelings that may interfere with optimal parent-child relationships. In addition, many of the new contraceptive methods carry medical hazards, enhance susceptibility to venereal disease, and can be seen as diminishing the shared responsibility of men.

Accurate information about the medical hazards of birth pills has not been generally available to most women, although the fact that there are dangers has been disseminated by the public media and is therefore a source of anxiety for many women. Tietze's data (129) suggest that the risk of death from birth control pills is greater than that from

childbirth—or from alternative contraceptive approaches including abortion—for all portions of a woman's reproductive career, except for women having frequent intercourse during years of peak fertility. After age 40, in adolescence, or for women having infrequent intercourse, regular use of the pill is not as safe as the alternatives. The safest methods for women—in terms of few side effects and some degree of protection from venereal disease and probably cervical cancer—are the diaphragm and condom, with back-up abortion. These methods have been viewed as psychologically less acceptable to women and/or their partners. The use of condoms, especially if the woman were the one insisting on it, would require a degree of sexual and general assertiveness that has not generally been a part of the behavioral repertoire of women—particularly adolescents, for whom this method would appear to be particularly indicated.

In 1969 Pohlman (130) reviewed research on the psychological aspects of family planning. Like so much of the literature on childbirth and contraception, this work suffers from an emphasis on the married couple; only 5 out of 444 pages of text discuss contraception out of wedlock! With the early adolescent population now the only group in our country showing an increasing birth rate (131), and with the current increase in both divorce rates and the acceptability of childrearing outside marriage, there is an urgent need for more research bearing on the psychology of family planning outside of the nuclear family.

There has been a series of studies on the psychological effects of abortion (e.g., reference 132). The trend appears clear. Some women do show adverse psychological sequelae but the incidence is lower than for term births. Psychologically (as well as medically), the data support the somewhat startling conclusion that abortion is safer than normal birth. This may be true in part because both internal and external difficulties in arranging abortions still are sufficiently great to make it more likely that the woman who is ambivalent about a pregnancy will carry it to term.

Comment

This discussion of women's sexual lives has been presented from a generally heterosexual standpoint. However, most of the same issues apply to lesbian women as well, who may also have functional or dysfunctional sexual relationships, be raped or fear rape, bear children voluntarily or involuntarily, and in general experience most of the same vicissitudes of sexual and reproductive life as do heterosexual women. Some research bearing on issues specific to lesbian lifestyles will be briefly reviewed in part two of this overview, but the topic is sufficiently broad to merit a separate paper.

Conclusions

We find the sexual and reproductive lives of women to be rapidly expanding research area of great pertinence to psychiatric theory and practice, with many research questions remaining to be answered. It is clear that much that has been previously assumed to be intrinsic to the psychology of women—or to the vicissitudes of accepting or objecting to the usual consequences of being a woman—needs to be reexamined. While we have not yet entirely ended the specter of involuntary sexuality and involuntary motherhood, or involuntary economic dependence on men, our society appears to be (ambivalently) moving in these directions. When young girls are generally socialized to expect to implement their conscious choices in these matters, women's attitudes toward women's (and men's) sexuality, assertiveness, and nurturance may well turn out to be very different from what is observed today. What we can expect to find will surely include the following:

1. Research done on women by women will often ask different questions and yield

different data that research conducted from male points of view on women construed as "the other."

2. Women will continue to have considerable individual differences from each other, as well as similarities.

3. Conscious choices about how to live as a woman will continue to be modified by economic conditions, culture lag in assimilating changes in the realities of women's lives and, undoubtedly, by a host of unconscious factors as well. Intergenerational envy and related fears and hopes of men toward women and women's sexuality, will continue to color women's sexual lives.

Researchers will continue to have the task of teasing out these multiple variables in order to understand women's sexuality in the context of other aspects of women's lives, although once again we will find as many questions raised as answered—a characteristic of any vitally expanding research area.

Seiden I. part 5

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OVERVIEW: RESEARCH ON THE PSYCHOLOGY OF WOMEN.*

II. WOMEN IN FAMILIES, WORK, AND PSYCHOTHERAPY

Anne M. Seiden, M.D.
Institute for Juvenile Research
Chicago, Illinois

In the first part of this overview the author reviewed research on gender differences in behavior and women's sexual and reproductive lives, and discussed the social and intellectual context of the recent knowledge explosion in women's studies. In this second part she reviews recent research on selected aspects of the social psychology of women's lives. Highlighted themes include women in relationship to family structure and child rearing, work and achievement motivation, and implications for the psychiatric treatment of women that can be drawn from the psychotherapy research literature. She briefly assesses the possible impact of research in these areas on psychiatric theory and practice.

All Human Cultures have some form of family or family-like grouping. In addition to "expressive" functions in living and loving, families serve multiple "instrumental" (1) purposes: to pool economic resources, support and stabilize adult personalities, and provide support in illness and disaster, as well as to share the tasks of child rearing and childhood socialization. Family and kinship networks may be built around a matrilineal or matrilocal family, patrilineal or patrilocal family, or other groupings of real or fictive kinship networks.

Family Structure and Child Rearing

Recent Western culture, and particularly American culture, is relatively unique in having as the norm a small nuclear family, with few enforceable obligations resting on other kin. This nuclear family is both highly mobile (the average duration of a mortgage in the United States is said to be 4 years) and often unstable (in 1975 the divorce rate of 4.8 per 1,000 population approached almost one-half of the marriage rate of 10.0 per 1,000 (2)). The contemporary isolation of many nuclear families from the tribe or extended family, with disruption of the female-female bonding system characteristic of many primates and traditionally dwelling humans, is a relatively new characteristic of mobile industrial societies (3). Particularly new is the combination of crowding-in-isolation (that is, a nuclear family crowded into a few small rooms, coexisting with relative social isolation of a housebound mother from extended family and other familiar adults). For primary child care, contemporary American society is distinctly unusual in relying far more heavily than most cultures on mothers alone, with variable but relatively little participation by older children, husbands, or other kin (4).

The "trapped young mother" syndrome has received extensive attention in the public media, and a number of studies have found that children add stress to parents' individual or marital lives in this culture. Studies of the 1960s, reviewed by Hicks and Platt (5), found children to detract from marital satisfaction. A major recent Quality of American Life Survey (6) found a sharp difference in reported satisfaction with life as a whole between young, married childless women (89% satisfied) and married women with young children (65% satisfied). Indicators of psychological stress were greatest for both men and women during the early parental life stage.

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The apparent effects of some of the previously discussed variables on the psychology of women have been to increase the importance of the heterosexual bond without necessarily increasing its stability, while decreasing the importance of other social bonds, such as those to kin, friends, and neighbors. The issue could be phrased as follows: one of the great national problems appears to be a maldistribution of child-care experience; some full-time housewives suffer from excessive contact with children and relative deprivation of contact with adults, while other members of our society may be virtually isolated from any meaningful contact with small children.

Day-care centers that are well run and employ adults who have chosen child care as their work have found that about 6 hours of direct child care per day is an optimal maximum (7). Full-time housewives may significantly exceed this, but by contrast, one study (8) found that a sample of middle-class husbands spent less than *one minute* per day in direct contact with their infants. This is a keenly felt deprivation for some men (9). Similarly, children in small families may grow up without any real experience in caring for younger siblings, and women whose children have left the home may mourn the total loss of child contact. Maccoby and Jacklin (10) have discussed evidence of the advantages of caring for younger children in the socialization of older children, and Goodall (11) has pointed out that some sharing of child care is common among chimpanzees, as it is in less industrialized human cultures (4).

There is a widespread belief that the structure of the American nuclear family has deteriorated. It has certainly changed. Our divorce rate is the world's highest. Although 80% of all divorced persons eventually remarry, children may spend prolonged periods of time with an overburdened single parent. In 1970 over one-fourth of American children under age 18 (and over half of our black children) were not currently living with both natural parents (12). It is estimated that by the time they reach 18, 35% to 45% of all American children will have spent an average of 5 years in a single-parent home (13). This is a sizable percentage, and it may reflect the fact that the divorced group who in a sense may need the support of a marriage most, i.e., parents of young children, may have the least opportunity to meet and bond with another spouse.

There are other striking changes in American family structure. In 1890 the average household consisted of 5 people, but in 1974 it was less than 3 due to fewer children and fewer other relatives in the home (14). Historical studies have indicated that the communally dwelling extended family was more characteristic of land-owning farm families than of urban ones (15), a condition that was in itself characteristic of a higher proportion of our population in 1890.

All of these problems are probably considerably greater in industrial society than previously because of the greater number of hazards that require close supervision of children and prevent their sharing in adult work and because of the marked increase in the length of the period of childhood dependency. Age 14, formerly the average year for entry into the adult work force, is today considered *early* adolescence—a period close to childhood during which the adolescent is often felt to require close parental supervision. The fact that we have not yet fully integrated the changed conditions over the past 100 years may represent a culture lag that is currently being addressed.

Effects on the Mental Health of Women

What effects do these unusual features of recent American family life and child-rearing conditions have on the mental health of women—and children? Much of the available data lies more in the realm of social commentary than research.

Moynihan—himself a successful product of a home broken by death—attracted con-

siderable attention by attributing black poverty and other social ills to the prevalence of single-parent homes (15). It is true that studies of child abuse (16) and of the psychological readiness of 6-year-olds for school (17) indicate the relative vulnerability of a single adult in caring for children, particularly under conditions of poverty. (However, the critical protective factor appears to be the presence of more than one adult, not the question of whether that other adult is a father, stepfather, grandmother, or even the mother's female friend.)

Mental health statistics have shown that married women are more likely than the unmarried to seek psychiatric help (18), to attempt suicide, and even if nonpatients, to report somatic symptoms indicative of psychological distress (19). In apparent contrast, the Quality of American Life Survey (6) reported that women as a group *exceed* men in self-reported overall life satisfaction under the following circumstances: married, aged 18-29, no children (17 percentage points greater satisfaction); never married; over 29 (12 points); never married, aged 18-29 (11 points); widowed (6 points); or married with children (3-1 points, declining as the children are younger). The greater life satisfaction of women over men thus appears to be very small for married women with children, much smaller than in other life circumstances. The possibility that even this small difference reflects defensive self-reporting is suggested by the higher incidence of suicide attempts and somatic symptoms in women compared with men in the same age range. In summary, single and widowed women report themselves as being satisfied more often than do single and widowed men; this difference increases during early marriage if there are no children but almost disappears if there are children. However, divorced women report themselves as significantly less satisfied than divorced men. Most have severe economic and emotional burdens in child rearing. Only 14% are awarded alimony, and only 44% are awarded child support. Less than one-half of these, i.e., 21% of all divorced mothers, collect child support regularly, and even then the payments are generally grossly insufficient (2).

Thus there is a striking contrast between the traditional belief that women require marriage and children for psychological fulfillment more than men do and the evidence that marriage, and especially the child-raising period, is associated for women with less happiness, more stress, and more overt mental illness. How does one account for this contrast?

One possibility, of course, is that women have simply been "sold a bill of goods"—been raised without accurate information about the toll that marriage and child rearing may have on their lives. Another possibility is that marriage and parenthood, like other desired goals, may be *both* a genuinely desired challenge and a source of stress and therefore increased risk of impaired physical and mental health. It is certainly not unknown for people to seek other pleasures, such as smoking, skiing, or high-pressure jobs, despite their known hazards to health or happiness. The research literature attempting to quantify stress in relationship to illness has clearly suggested that positive life events may be as stressful as negative ones (20).

It is highly likely that some of the toll exerted by child rearing and perhaps marriage as well arises from intrinsic stress and lack of accurate anticipatory information, as well as from lack of economic support. This suggests that it is important for both clinicians and the population at large to have a realistic appraisal of the occupational hazards of child rearing and the need for adequate support and backup. We are not in a good position to understand and mitigate these costs if we simply deny them.

part 2

Changes in Child-Rearing Practices

A variety of approaches is currently being used to mitigate the psychological costs of

child rearing, while preserving the benefits. Currently, women themselves are increasingly seeking extrafamilial employment during the child-rearing years (21) and planning on having smaller families (12). The generally low salaries received by employed women suggests that the motives for employment are not entirely economic (21).

Suggestions have been advanced for the modification of men's career patterns (9), provision of professional or neighborhood day-care homes (22), employment of "foster grandparents," and the like (23). Even the realistic appraisal of stress and symptoms as a time-limited occupational hazard, rather than necessarily evidence of personal pathology, might be expected to be beneficial. Few of these suggestions have been carefully evaluated in terms of their impact on the satisfaction and health of women, men, and children. This appears to be an important area for social-psychological and clinical research in the future.

Psychology of Women at Work and in the Community

Some of the material pertinent to this section has already been examined in the discussion of child rearing. This is appropriate, since housekeeping and child rearing are work, whether they are counted as employment or not. In addition, the burdens and satisfactions of housework and child care continue to fall more heavily on women than men, regardless of the women's employment status (24). Sometimes this is by the women's choice, sometimes it is a matter of guilt, and sometimes it reflects an unrealistic commitment to the "superwoman" role. Childhood socialization may play an important role in that the woman who has already learned how to cook, clean, and manage a household efficiently may despair of teaching those skills at a later age to a husband who has not learned them. Even women who are employed have been observed to teach household skills to and require household duties from daughters more than sons (25), a situation that is likely to perpetuate the imbalance. Perhaps all of us would enjoy the idea of having a personal servant, and to some extent, enjoying this role vicariously by performing it for others may be easier than giving it up. It is also true that in work situations there is still a pronounced tendency toward failure to recognize women's real competence (26), and the maintenance of domestic competence greater than her husband's may remain a source of compensatory self-esteem for the woman employed outside the home as well as in it.

Bardwick (27) summarized evidence showing that the present cohort of middle-aged women begin to evidence increased dissatisfaction with a housewife-only role after about 10 or 15 years. Whether this length of time will continue to be salient is a matter of speculation, but current data (28) suggest a sharp increase in the number of college women with plans for little if any interruption of their careers.

At present, most adult women are employed outside the home; they constitute 40% of the paid labor force (29, p. 33). Statistically, they hold lower-status, lower-paying jobs than men do, a gap that is widening rather than narrowing (29, p. 47). This condition may pose psychological if not economic problems for the relatively affluent married woman whose husband provides support and family status. However, a substantial number of women provide total or major support for themselves and their families, if any; and another substantial portion are keenly aware of the need to have their daily activities receive social validation in terms of money and/or respect. Guilt about or pragmatic conflict between the demand of occupational roles and maternal roles sometimes poses problems for women (30). This is in large part a function of the woman's income and job status: absenteeism, including that for child-care reasons, is slightly higher among female than male employees (5.6 versus 5.5 days per year). "Quit rates" for women are higher than for men (24 per 1,000 versus 18 per 1,000) and notably so among the higher

portion of women in less skilled jobs, who lack control over their working hours and receive pay at about the same level as available surrogates (31). Of course, fathers rearing children alone have many of the same problems, and their number is increasing with the acceptance of single-parent adoptions and the decrease in the convention that the mother is automatically to be favored in obtaining custody after divorce.

The increasing number of women who say they are working for fulfillment rather than or in addition to economic necessity deserves serious consideration. Pay may not do much more than cover increased expenses due to employment. There are those who wonder about this trend, noting the apparently mundane character of many jobs that are taken for "fulfillment." Ultimately, this will require reexamination of our assumption that only well-paid, high-status, or influential jobs provide fulfillment. It is probably a remnant of the American upward mobility-success tradition. The need for companionship in one's daily activities is fairly widespread, as is the need for producing a tangible product, which household maintenance does not.

There is now an extensive body of work on motivation for occupational achievement in women. Horner's early studies (e.g., reference 32) suggested that some kinds of achievement that were relatively unambivalently valued by male college students were perceived as dangerous or conflictual for college women. She postulated a fear of success among bright women. A number of replications and extensions in this area have begun to tease out some of the relevant variables. For example, success motivation for competitive tasks in men tends to disappear in the absence of an audience, while the opposite appears to be true for women (33). These and other studies suggest that achieving women have learned to fear that society might punish them for that achievement, particularly if it is perceived as deviant, while achieving men have learned to expect societal reward to maintain their behavior.

The large body of literature on conditions of work for employed women and the effects of their employment and employment conditions on children has received four major fairly recent reviews (21, 34—36). The trend of this research appears to indicate that children do best overall when mothers who prefer to be housewives can be housewives and when mothers who prefer employment can have it. While earlier work had looked for and found adverse effects of employment among mothers (such as inadequate supervision, especially among poverty groups), more recent work has looked for and found both positive and adverse effects, both of which occur in interaction with other variables. For example in one study of working-class depressed women and normal neighbor controls (37), the percentage of employment was about the same among both groups, but the depressed women were more likely to dislike and function poorly at their jobs and to have impaired relationships with their children, regardless of whether the job was that of a housewife or a paid employee. Interestingly, in another study (38), employed women recovered more quickly from depression than housewives, even when they were employed because of economic necessity. The household milieu may be understimulating for a depressed woman, even if she prefers it when not depressed.

Women's Friendships and Love Between Women

There is now a growing body of literature regarding female-to-female social network at present and historically (39). It is interesting that much of this discussion is also relatively new. Normative social-structural models have been based on the heterosexual pair or the male-male bond as the primary units of the social structure (40). In these models female-female bonds are regarded as of secondary importance, supportive to the social structure or a way of filling in time in the absence of the "more important

heterosexual or mother-child bonds. Yet there is abundant evidence that women's friendships have always been an important part of the social fabric, relatively neglected only in early 20th-century social theory (41).

As Smith-Rosenberg (41) observed, extremely close, warm, devoted relationships between women were common in previous years and were expressed openly in affectionate correspondence that has apparently been a source of embarrassment to some modern historians. Major areas of help that women gave to each other, and continue to give, include emotional support in times of crisis or loneliness and practical help with such events of the female life cycle as birth, gynecological problems, and illness and care of the sick. There is a fairly widespread tendency to disparage the kaffeeklatsch conversation of women, but research on widowhood has disclosed that a greater number of men have intimate conversations only with their wives, while women are more likely to have a female confidante as well. The fact that the mental health and happiness of single and widowed women is generally better than that of single and widowed men has been attributed in part to the supports available from female friendships (42).

Some women who previously felt competitive or anxious with other women have cited the women's movement as providing them with significant female friendships for the first time. However, a pilot study of friendships among women active in the movement did not confirm this as a representative development (39). Most of these women had had important friendships with women all their lives; what the movement had provided in most cases was a new legitimization of the value of these friendships.

The distinction between close female friendships and lesbian relationships appears to have been confusing for many professional and popular writers. There has been a significant scotoma in both law and social science, which may have worked to the advantage of lesbians: laws against homosexual behavior have almost never been enforced against women, although there have been some recent problems concerning child custody. Smith-Rosenberg (43) noted that Victorian medical texts, fearing the imagined dangers of masturbation, noted that "some of these girls (in boarding schools) teach each other to masturbate, and some of these women do not want to marry" without apparent awareness that "teaching each other to masturbate" referred to lesbian sexual relationships.

In fact, lesbian women make the same distinction between friends and lovers that heterosexuals do, and heterosexual women do not appear to be as confused or anxious about the distinction between close friendship and sexual intimacy as men do. "Homosexual panic" as a clinical entity appears to be far more common among men than women, although Deutsch (44) theorized that it might be a problem for widows.

Until recently, there appears to have been a relative paucity of research literature on lesbianism and an even greater neglect of what research was available. Thus Sherman (45), in a relatively comprehensive and recent text on research on the psychology of women, had no section on the topic. A bibliography from the American Psychological Association on the psychology of women (46) contains only four references to lesbianism, and only one of them is a research paper. A bibliography from the National Institute of Mental Health (47) lists only six research papers. These studies, for the most part directed at comparing the prevalence of symptoms in heterosexual and homosexual male and female samples, generally found small differences or none. (Several studies showed a slightly higher frequency of depression, drug use, or suicide attempts among homosexual populations, but a majority of the homosexuals functioned as well as the controls on the dimensions studied.)

The literature reviews that do exist (48, 49) do not include references to studies of les-

bian women as mothers, which is a serious omission in view of the fact that expert testimony is often sought in child custody disputes. Recent research is filling this gap (e.g., reference 50).

The available literature indicates that lesbians tend to have or seek lasting relationships more frequently than male homosexuals do (e.g., reference 51). One recent study comparing unmarried young lesbian women to their heterosexual counterparts (52) found that both groups had about the same percentage of transient, deepening, and cohabiting relationships expected to be permanent and about the same percentage of depression and other psychiatric symptoms. Both groups, of course, are under some similar social pressures, e.g., to marry and/or to conceal the status of their sexual relationships. The fact that these pressures are generally conceded to be considerably greater for lesbians might have predicted a greater incidence of symptoms, but this was not found.

Lesbian relationships in previously heterosexual women are beginning to receive some research attention. In some cases the women themselves regard their previous heterosexual experience as an attempt to deny a lesbian orientation that they trace to earlier years. However, there is also a distinction between "political" and "personal" lesbianism. That is, there are some women who have felt that participation in the women's movement either ideologically contradicted, or personally made difficult, relationships with men (39, 53). Confining love relationships as well as friendship relationships to women then became a political statement or a practical necessity or both.

Impact of Recent Research on the Clinical Treatment of Women

Depression and Schizophrenia

The literature on depression is of obvious pertinence, since a greater proportion of patients diagnosed as having overt clinical depression are women, with reported proportions varying from 2:1 to 3:1 (54, 55). Genetic research has suggested that endogenous affective disorder may be transmitted as an X-linked dominant gene, thus giving women twice the vulnerability of men (56). At the same time, ego-psychology, sociological, behavioral, and animal models converge on noting the similarity between the "learned-helplessness" model of vulnerability to depression and stereotypical female sex role expectations (57). While continued controversy in this area is likely to be with us for some time, integrative models are appearing, and the attention given to the controversy itself is likely to heighten clinical attention to diagnostic criteria. At the very least, "learned helplessness" would appear to pose special hazards to persons biologically vulnerable to depression, while exclusive attention to either social causes or their psychodynamic reflections would run the risk of ignoring biologically treatable conditions.

While schizophrenia is currently a condition that is more likely to be diagnosed in men than women, the whole subject of the true prevalence of schizophrenia is at present considerably clouded. It appears likely that in American psychiatry there has been a trend to 1) overdiagnose schizophrenia when bipolar affective disorder would now appear to be the more accurate diagnosis (58) (thus perhaps overrepresenting women among the listed hospital schizophrenic populations), and 2) diagnose schizophrenia more often in men than women, in that the marginally functioning but quiet and nonviolent schizophrenic, more often female, may never be hospitalized and thus not receive a diagnosis. (In other words, schizophrenia together with male aggressiveness may be perceived as more dangerous and therefore may be more likely to result in hospitalization.) Thus the true prevalence of the disorder in men and women is unclear and is likely to remain so for some time.

In Chesler's intriguing social-psychological model (59), depression is seen as a disorder consisting of exaggerated female sex role behavior, while schizophrenia in both sexes is seen as a disorder based on radical rejection of assigned sex roles. While the clinical observation appears accurate—schizophrenic patients of both sexes *are*, frequently conflicted about gender-prescribed behaviors and even basic gender identity—I lean toward regarding this as a secondary symptom rather than a primary one. It seems more likely that the elaboration of sex differences at adolescence (a time at which many schizophrenics begin to experience especially severe difficulties) is sufficiently complex and unrealistic enough to make it harder for a person with a basic schizophrenic thought disorder to navigate the course. If this is true, relaxation of sex role rigidities would not be expected to reduce the true prevalence of schizophrenia, but it might have the important effect of decreasing the magnitude of the adaptive task for schizophrenics (and others).

Psychotherapy Research

The field of psychotherapy research is enormous, complex, and fascinating. Probably the most solid finding in the entire body of work is one that is frequently ignored because it is, of course, threatening to us as clinicians: psychotherapy has the potential for accelerating deterioration as well as producing beneficial effects under certain conditions that are not entirely understood (60, pp. 246-252; 61). While this is what one would expect of any powerful therapeutic agent, we have been hampered in applying appropriate cautions by a relative lack of solid data about specific therapeutic conditions that should be cause for concern. Current feminist work may be helpful in bringing the question of adverse effects back into the central focus that it deserves. Specific criticism by feminists has highlighted the following areas (also noted by others):

1. Sexual abuse of the therapeutic relationship is more common, and at least sometimes more devastating, than has previously been recognized (61). Problems in this area may be further compounded by the therapist's use of overt or covert threats of various sorts to prevent disclosure (62, 63).

2. The perhaps more subtle but related danger is that the therapeutic relationship in a dyad may replicate rather than remedy the "one-down" position in which women frequently find themselves in life and marriage, thus encouraging the fantasy that an idealized relationship with a more powerful other is a better solution to life problems than taking autonomous action (59).

3. Therapeutic theories have more often supported rather than questioned stereotypical assumptions about sex roles, with different standards of mental health for women and men (64), including the assumption that dependency, masochism, and passivity are normal for women and the tendency to treat assertiveness and aggression differently for women than for men.

4. Women specifically, especially when treated as collaterals to their children, may be harmed by a "blame-the-mother" tradition in clinical psychopathology (vide the considerably greater and earlier literature on allegedly schizophrenogenic mothers than fathers, despite lack of clear evidence that either is specifically responsible for the more serious disorders of their children).

5. There has been a lack of realistic appraisals of the occupational hazards of the housewife role.

Part 3 of Women in Families

Special Issues Related to the Gender of the Therapist

While therapist gender is often considered in making an assignment of clinic patients,

There are relatively few solid data on differential outcomes by diagnosis and other patient characteristics. Luborsky and associates (65) found that in dynamic psychotherapy, favorable outcomes were more often obtained when the therapist and patient resembled each other in terms of *all* measured demographic variables (including gender, age, marital status, religion, and social class origin). Orlinsky and Howard (66, 67), reanalyzing data from the 1960s, were able to make more precise recommendations for female patients. They found that having a female therapist was more likely to predict a successful outcome for women patients as a group but that most of the variance was accounted for by women who 1) were relatively young and unattached (i.e., not married or mothers), and 2) had a diagnosis of depression. In this age-diagnostic group they found that with male therapists, more time was spent talking about the therapeutic relationship itself, including erotic transference, but that female therapists were more likely to be perceived as supportive and helpful and were more often associated with overall patient satisfaction. For women in other life-status and diagnostic groups, these differences between male and female therapists were less pronounced.

It has been argued, quite possibly with some merit, that the gender of the therapist is less important in psychoanalysis than in therapies of lesser intensity and extensiveness. This argument states that there is time and scope in analysis for the development and resolution of both maternal and paternal transferences, regardless of the therapists' and patients' actual genders. Even assuming its validity, the argument would be more persuasive to analysts who hold that the formation and resolution of transference neurosis alone is the effective ingredient in analysis; it would be less persuasive to those who hold that corrective emotional experiences, or provision of role models, are also important ingredients. Actual data on differential outcome are relatively rare.

Regardless of the ultimate preference that different kinds of female patients have for a therapist of the one or the other gender, there are a few issues in therapist training that are likely to have a special impact on the work of female and male therapists with female patients.

Female therapists are much less likely to have had as many supervisors of their own sex as role models during training; some may have had none (68). In this regard they may be more likely to have experienced conflict between their therapist identity and their own gender identity. If this issue is worked through it is likely to have been perceived as a source of professional growth (69), but if it is denied there may be special problems in identifying with less privileged women. The conscious or unconscious position that "there is no problem; if I could succeed so can you" can be a bar to empathy, as can a countertransference position of pleasure at seeing women like those who in high school belonged to a popular social set now developing problems that the therapist—perhaps a "grind" in high school—now escapes (70). In addition, perhaps because of relative lack of female supervisors, and perhaps because of a general cultural denial of women's homosexual feelings, homoerotic transference issues may have been less carefully dealt with in the supervision of female therapists with female patients.

Male therapists are likely to share in the dearth of female supervisors and therefore have more learning experience in the discussion of women's difficulties from a male perspective than from a female perspective, where these perspectives differ. Androcentric bias in the male therapist ("male chauvinism") is probably less likely to have been corrected in professional training than gynocentric bias in female therapists, who generally receive extensive exposure to male psychiatric points of view. Erotic transference cuts both ways in the male therapists' treatment of female patients: it may provide for a more rapid mobilization of interest in the therapeutic relationship and may provide either

gratification or anxiety for the male therapist, but he is likely to receive supervisory help in that male supervisors have generally shared this experience. Since the female patient and male therapist (like most persons) are more likely to have had a closer early relationship with their own mothers than their fathers, collaboration in a mutual recognition of anger at the mother and their problems with her may speed the reevocation of pedipal feelings but slow the resolution of them.

None of these problems is by any means insuperable, but more explicit recognition of them in training and the provision of supervisors of both sexes for work with patients of both sexes is likely to be helpful.

For all therapists, it is likely that changing roles and expectations of women and men are likely to bring new issues in this area into focus in treatment over the next few years. Further, therapists of both genders may well find that gender-specific transference and countertransference issues that they learned to recognize and handle during training may change over the life cycle as the therapist's own age, marital status or satisfaction, and life circumstances change. Continuing education and occasional consultation may be very helpful in keeping up with both the changing times and the therapist's own changing experience of these issues.

Effects of Women's Movement on Clinical Treatment

Data on the effects of participation in feminist activities on the mental health or psychological organization of women are thus far sparse and largely anecdotal. Some individual women speak with great enthusiasm of their own gains from participation in the movement, indicating at the very least a charismatic effect of the sort that Vaillant (71) recommended as an alternative treatment modality. Bernardez-Bonesatti (72) showed that there were differences between feminist and nonfeminist applicants for outpatient psychotherapy, with feminists showing less passivity and greater self-esteem.

Feminist therapy, even when provided by well-qualified professionals, has attracted some degree of suspicion regarding both its clientele and the therapy itself (73). While suspicion within the women's movement centers on the motives for a therapist's willingness to take an elite position and charge a substantial fee, suspicion from the professional side is more diffuse. At a recent annual meeting of the American Psychiatric Association, in a session on feminist therapy, two psychiatrists in widely different parts of the country described their male colleagues' apparent anxiety at the idea of all-women therapy groups (74, 75), despite the fact that same-sex therapy groups have been widely used for other groups such as prisoners, the clergy, and adolescents. Economic issues may be one explanation; in major metropolitan areas female psychiatrists currently report that they have insufficient time to accept all their referrals at a time when some male psychiatrists are having difficulty filling their schedules. Feminist therapists have reported their experience in successfully treating women who felt that they had prior treatment failures with nonfeminist therapists, and the reverse also occurs (76).

At present, feminist therapy has some of the characteristics of a "school" of psychotherapy, although, of course, many members are also adherents of other therapeutic schools or of informed eclecticism. Feminist therapy has its own rosters of therapists, body of research and clinical literature, and special sessions at major meetings of mental health professionals.

Major trends in feminist therapy appear to include a grounding in current research about women, a relative priority given to environmental interpretations rather than intrapsychic ones, and a trend toward greater egalitarianism between therapist and patient. Other characteristic trends include a careful avoidance of using the therapeutic situation

to replicate the one-down position that women often take in marriage or work, a hearty laugh at the idea that a healthy woman is characterized by passivity, and an attempt to provide a good role model in the form of a competent woman. None of these characteristics taken individually distinguishes feminist therapy from all other schools, but the constellation apparently is either unique enough, or perceived as unique enough, to have created a demand.

There are, of course risks. For example, the previously reviewed literature on the "fear of achievement" suggests a prevalence of internalized conflict about achievement among many able women with achievement goals. In therapy a total neglect of internal conflict might lead to ineffective therapy in these and other areas. There is a further risk in that feminist patients are no more immune to organically determined disorders than are other people, and thus far a majority of feminist therapists are not psychiatrists. For example, a woman with a genuine bipolar affective disorder, who needs pharmacological as well as psychotherapeutic help, may have difficulty in finding a therapist who is both a pharmacologically competent psychiatrist and a feminist, or a psychiatrist who is willing to collaborate with a feminist therapist.

Discussion

It should be clear from this overview that we now have available a large body of recent and important research data on women that must be sifted, evaluated, and fed into the development of appropriate theory about women. This paper is intended to be a step in that direction, but one that is necessarily preliminary at this time. Since the body of research referred to has largely been produced within the last decade, much of it during the early 1970s, it appears unlikely that we will have a body of studies that have been replicated, critically reviewed, and assimilated into the field before the next decade. In the meantime there will be a considerable need for psychiatric researchers (and, of course, researchers in related fields) who possess a diverse repertoire of research skills and familiarity with the literature in this field. Urgently needed will be women's studies scholars who cross disciplinary lines, e.g., having *both* clinical experience and knowledge of historical, anthropological, sociological, or psychometric methodologies.

Importance of Recent Research to Psychiatry

There appears to be considerable potential for an exciting enrichment of general psychiatric theory, research, and practice. For example, in a fairly recent review of psychiatric research during the period 1963-1972, Brodie and Sabshin (77) reached the following conclusions, among others:

One of the striking findings of this survey involves the paucity of papers on the social causes of psychiatric illness. Social psychiatric concepts had produced important formulations about etiology during the 1950s... (78, 79), and by the beginning of the 1960s it appeared that we were on the verge of developing new constructs to account for social factors in psychopathology. Quite clearly, these new constructs have not emerged between 1963 and 1972 and this void may represent a significant commentary on the past decade. (p. 1316).

There are a number of reasons for believing that research in the area reviewed here may contribute in the future to the breakthrough that Brodie and Sabshin had anticipated but did not find in the 1960s or the early 1970s.

1. The implications of sex-role typcasting for psychopathology or symptom expression are just beginning to be plumbed. As Dohrenwend and Dohrenwend noted in a comprehensive review of the influence of social and cultural factors on psychopathology (19),

it has been difficult to compare the major psychiatric epidemiological studies. Major questions of theory, which in some instances could turn on questions of fact, have been left unresolved because of methodological problems. These problems include overlooking sex-role differences. For example, women are consistently shown as more likely to be diagnosed as neurotic, and men as sociopathic. But whether sociopathy is considered to be "mental illness" varies so greatly from study to study as to make results noncomparable. Widely used symptom scales, such as the 22-item screening instrument from the Midtown Manhattan study (80), "are more representative of female than male modes of expressing distress" (19). Clearly, before the complex literature on social causes can be sufficiently clarified to yield grounded theory, it will be essential to give the kind of careful attention to sex differences that has been characteristic of the current work. This will involve carefully looking for sex differences and attempting to pin down their sources rather than using stereotyped explanations, as well as giving careful scrutiny to alleged sex differences to see whether the data really support their existence.

2. The current research includes much work on the distinctive events of the female life cycle, such as the biopsychological and sociopsychological aspects of menarche, sexual relationships, childbirth, lactation, early mother-infant bonding, and menopause. This is studied in relationship to other events of the female life that are not uniquely female, such as education, employment, child care, adaptation to illness, bereavement, and aging. Although many of these topics have been studied in previous research, we have had surprisingly little integrative work uniting them. The newer work will be important both in understanding the etiology and pathogenesis of psychological distress in women and in understanding women's participation in social networks that alleviate or exacerbate psychological distress in others.

3. For the first time we have a large number of well-trained investigators who are doing research on women and who are women themselves and have experienced a number of the life events under study. The issue is similar to that regarding studies of other minority groups; while no one would be likely to make a convincing argument that *all* of the research about a particular minority group should be done by members of that group, there compelling reasons why *much* of it should be (81). Researchers from a privileged group outside the group being studied are at risk of having shallow conceptualizations, lack of emphatic understanding of the salient variables, and perhaps a different axe to grind. Further, there has been a strong criticism that research done from the "outside" is not as likely to be conceived or later used in a way that benefits the people "inside" the group in question. A persistent concern in psychiatric research related to social problems has been the considerable gap between research and application. Sometimes the gap may occur because the investigators themselves are not particularly interested in implementation and sometimes because the research is too poorly conceived to merit application. The infusion of numbers of investigators who belong to the group whose ox is being gored is probably the best remedy to this situation, and it can be expected to result in better research and quicker dissemination and application of findings.

4. It is even possible that the current increase in the number of women entering medicine and psychiatry, and the rapid expansion of women's studies as a related research field, may yet contribute to the hoped-for transformation of psychiatry into a more research-oriented field (82, 83). This appears to have already occurred within the field of psychology, where the great discrepancies between what women have experienced for themselves and what psychological theories say about women have acted as a powerful stimulus to research curiosity. Women who are learning not to accept an argument from authority when it refers to women, who are learning to demand to see the

evidence and review and gather it for themselves may, it is hoped, continue to carry these healthy attitudes over into other areas of psychiatry. The result could only be stimulating and beneficial for our field and all of us.

Before about 1970 we saw such remarkable phenomena as an APA Task Force on Psychiatric Aspects of Family Planning that had no women members (84) and the official APA journal that published papers dealing with issues affecting women's lives, such as psychotherapy, family life, abortion, and early child care, but had no women on its editorial board (85). In addition, the published proceedings of a conference sponsored by the National Institute of Health on menopause and aging listed 25 participants, all men (86); clinicians who primarily treated female patients were without formal education or background in women's perceptions of treatment issues; and research site visit committees and review panels often contained no women members. There has been a kind of (often unconscious) arrogance in the willingness of male professionals to tell women how to define their problems and lead their lives and, in parallel, a curious willingness of women to accept male definitions of women's needs. However, today's climate contains some important differences. Since 1967 women have not only had legal rights of equal access to professional education and advancement, but have increasingly felt a sense of responsibility for taking part in the groups and deliberations that define women, whether in research or in clinical treatment.

WOMEN IN FAMILY part 4

"Psychology of Women"

"Psychology of women" is a complex concept. The topics previously discussed all pertain to women, but to consider them as constituting a subfield of psychology or psychiatry poses serious theoretical problems. As noted by Parlee (87) in a sophisticated review of issues and research in this area, the term "psychology of women" implies that psychology needs a special set of laws and theories to account for the behavior of women. "The bland assumption that males are more representative of the human race than are females may have created an unknown number of pseudoproblems for psychologists" (87, p. 127). This includes both the failure to detect important and interesting sex differences when they do exist and the failure to refute assumptions about sex differences when they do not exist.

Women are less often subjects in psychological research than are men (88-96). Indeed, in a review of psychological journals one investigator found that female authors were more likely than male authors to have analyzed their data for the presence or absence of sex differences (96). In addition, the question of whether women or men serve as subjects of an experiment tends to depend to some extent on the problem being studied, i.e., studies of aggression are more likely to use only men, while studies of interpersonal attraction contain a higher proportion of female subjects than studies of aggression do. Further, studies are frequently reported and summarized in such a way that findings from those studies conducted on men are generalized to everyone, while results from studies employing women are generalized only to other women.

Generally held assumptions about sex roles or sex differences are often introduced into what purports to be scientific work without the perceived need for supporting evidence. For example, a book reporting clinical research on environmental effects on behavior disorders (97) listed failure to cook her husband's breakfast as ipso facto evidence of pathology in a female patient!

Research findings are likely to be reported or abstracted in biased ways. Male-normative linguistic habits are common and revealing as, for example, in the use of the term "superior" for higher scores by men when "scored higher" was used for higher

scores by women (87). It is conventional in research as well as in clinical settings to use generic male terms to refer to persons of both sexes or to positions that could be filled by persons of either sex (e.g., "man and his cities," "chairman" rather than "chair" or "chairperson," and "attending man" for "attending physician"). Available research data (98, 99) indicate that these are not merely neutral linguistic conventions but do have the expected effect of inducing the reader to expect the positions to be filled by a man.

Beyond the use of language there is the problem of inaccurate and/or misleading references to primary data (including the investigator's own data). For example, Asch (100), in discussing the mental and emotional problems of pregnancy, stated that "problems about eating are deeply rooted in the psychology of the pregnant woman" and then cited data that appear to support the opposite conclusion, i.e., an extreme emphasis by clinic staff on avoiding weight gain had been transmitted to patients (avoiding weight gain is now known to be obstetrically contraindicated). Many authors have cited Spitz's (101) and Bowlby's (102) work as shedding light on *maternal* deprivation alone, whereas reading the original reports suggests that sensory and social deprivation were major issues.

Indeed, findings are likely to be explained in stereotyped ways even when support is available for alternative explanations. For example, one study (103) ascribed female toddlers's staying closer to their mother than did male toddlers to "timidity," just one page after noting that mothers had reinforced proximity-seeking in girls while more frequently ignoring it in boys.

Clearly, major biases such as these in the conduct and interpretation of research do not arise by unmotivated accident. An objective and value-free science is a goal rather than something to be consistently expected in real life. Current thinking in the philosophy of science (104), sociology of knowledge (105), and the psychology of effects of expectancy (106) reconfirm our recognition that almost all knowledge has its political and wish-fulfilling contexts. The same point has been made with respect to clinical practice (107, 108). Psychological data about women can be gathered or used in quite different ways, depending on what one wishes to do about women. Henley (109) made a distinction between "psychology of women," "psychology against women," and "psychology for women," pointing to the ways in which data about women can be gathered and used to stereotype women, to "put women in their place," or to be helpful to women.

Literature on the "psychology of oppression" (110, 111) arises from noting the similarity between stereotypical views of women and stereotypical views of other disadvantaged (but sometimes ambivalently envied) groups. Thus women, like blacks, have been described as "inconsistent, emotionally unstable, lacking in a strong superego, weaker or less often healthy, artistic rather than conceptual, nurturant rather than productive, intuitive rather than intelligent... if she knows her place she is really a quite lovable and loving creature, happy and childlike" (112, p. 81). Similarly, women are said to be more manipulative, devious, inscrutable, and erratic; it has been accurately pointed out that these are characteristics to be expected from any group that has access to power and economic support only by means of pleasing another, dominant group. An accurate analysis of such stereotypy requires recognition of both true difference (reflecting different coping mechanisms) and perceived but untrue differences (arising from observer bias, lack of knowledge, and/or projective mechanisms).

By contrast, literature on the "psychology of gender roles" arises from noting that there is a division of labor in most human societies which rests in part on reproductive biology and in part on cultural elaboration of the consequences of biological differences. Women are expected to give birth, rear children, feed people, and perform other tasks that a socie-

ty views as consistent with these responsibilities (whether the individual woman has children or not). Men are expected to perform the residual tasks. Female gender role behavior may then be seen as more firmly grounded in biology (113), with more clarity and "inevitability" or "rightness" attached to it. Male gender role behavior correspondingly is seen as less certain and clear, less biosocially predictable, more subject to change according to social circumstances, more a product of culture, more an achieved than an ascribed status, and perhaps thus for the individual male more of a source of uncertainty, anxiety, and confusion (113, 114).

The role differences between the sexes are often sharply contrasted, often at the price of oversimplification, in the hope of making life simpler or more comprehensible. Clearly defined status and gender roles, where everyone "knows his or her place," are said to be one of the advantages of stratified societies, even when rigid roles result in inequity or blurring of individual differences. On the other hand, fear or envy of prerogatives of the opposite sex, or aggressive or defensive behavior against the opposite sex, is so common as to have received a special term—"the battle of the sexes." There is in fact a long and remarkable tradition of misogynous writings, both scientific and literary, reflecting the fear of women or women's sexuality. This literature has been historically documented by Hays (115), Lederer (116), Rheingold (117), Sherfey (118), Bachofen (119), and others. An attempt to reverse these biases and traditions would constitute a genuine and important scientific revolution.

Scientific revolutions are often, at the beginning, more conceptual than empirical; a new point of view often reorganizes old data before it stimulates the search for new data. The new point of view surfaces in a particular context of scientific and/or political crisis (104) (it is rarely as new as it later appears (120)). It may stimulate anxiety, opposition, and blind discipleship quite as much as it does the objective search for facts.

Thus it has been observed that there were particular resistances to assimilating the work of Copernicus, Darwin, and Freud. The heliocentric model removes our earth from the center of the universe. Evolution makes "man" no longer the species uniquely created to govern this earth. The dynamic unconscious makes "man's" conscious motivation no longer master in "his" own soul.

In this sense the feminist perspective also appears to imply a genuine revolution in social psychology. Man—the male half of the species—is no longer to be viewed as its prototypical member, with female psychology the psychology of the "other," the exception, the supporting cast. In my opinion, the implications of this different perspective will ultimately go far beyond the simple accumulation and assimilation of new data about women.

Directions and Expected Impact of Future Research

We may expect that some applications of some of the current work may be made in ways that in retrospect will appear to have been unnecessary or misguided. In particular, the current controversies among biological, social, behavioral, and intrapsychic approaches may be expected to yield, to some degree, to more integrative approaches.

Over the next decade we may expect to see a sustained increase in the number of women involved in psychiatrically related research, as well as research administration and evaluation, thus participating more equally in choosing the topics and determining what studies receive funding.

We should also expect a continued growth in research attention to areas particularly bearing on women's lives. We may hope to see clinical practice related to such areas as women's biosocial psychology, childbirth, childbearing, vocational issues, and marital

relationships to be increasingly based on solid research findings rather than the translation into professional language of what is essentially folklore. Appropriate revision of theory should help to increase the sensitivity of our third ears. Better attention to the mental health needs of boys and the effective management of male—and female—aggression in a civilized society may be important aspects of meeting the needs of women and society as a whole.

Until a short time ago it appeared to many that the continued expansion of our industrial society might make the conquest of leisure, and leisure-time personal relationships, the largest social problems for the future. Current ecological and energy crises have clarified some of the limitations of these approaches (121). The "greening of America" (122) no longer appears to be an unlimited, automatic next step. It appears that work will continue to be an important part of the lives of women and men, and the appropriate balancing of work and achievement needs, as well as other personal human needs, will be important issues affecting everyone. This will inevitably be reflected in psychological theory and research and in clinical practice.

"Futurology" is becoming something of a specialty in itself. By definition it is an extrapolation from present research rather than a research field itself. It seems a safe extrapolation to predict a continued advance in the area of women's studies and a greatly increased impact on psychiatry in the near future. This field is so new that we do not as yet have any psychiatric residents who could have had four years of exposure to it as college undergraduates, but the first of that group is now in medical school, and they will be beginning to enter our residencies in 1978. It should be an interesting decade ahead for all of us.

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PSYCHIATRISTS' RESPONSE TO SEXUAL BIAS IN PHARMACEUTICAL ADVERTISING*

Christine McRee, M.D.

Billie F. Corder, ED.D.

Thomas Haizlip, M.D.

Child Psychiatry Residency Training Program

Dorothea Dix Hospital

Raleigh, N.C.

Of the psychiatrists responding to this study's questionnaire, 45 percent perceived pharmaceutical advertisements from a randomly selected issue of The American Journal of Psychiatry as showing sexual bias that might negatively influence physicians' perceptions of women. The perceptions of the responding psychiatrists concerning additional implications of the predominance of women "patients" and sexually biased advertising copy in drug advertisements are reported and discussed.

Repeated portrayal of "typical" behavior patterns in various communication media is widely accepted as having effects on female and male identification and role modeling (1). Texts and illustrations perceived as indicating sexual bias in medical and health areas have been nationally controversial, as reflected in the number of recent publications devoting chapters to the subject (2, 3). It is surprising, then, that three randomly selected issues of *The American Journal of Psychiatry* (December, April, and May 1973) carried pharmaceutical advertising for drugs used in psychiatric treatment in which 64 percent of the "patients" illustrated were women. The advertising copy showed these typical comments: "Help release her from her severe anxiety, then she can open up to you"; "She doesn't respond to things"; and "Can this hospitalized schizophrenic relate to herself at all?"

Recent letters to the editor of *Psychiatric News*, official newspaper of the American Psychiatric Association, have expressed concerns over similar trends in that publication's advertising; one letter stated that 11 out of 14 pharmaceutical advertisements in the July 4, 1973, edition depicted women, usually as depressed and passive patients, while only 3 showed men and 1 showed an inanimate object (4). One of these letters accused the pharmaceutical companies and the publication of having a "tendency to foster and stabilize stereotypical roles of American Women as 'sick' " (5).

Published responses to these types of allegations have seldom dealt objectively with the questions of whether physicians themselves view such advertising as biased, how they perceive themselves as affected by sexual bias (if perceived as such), or how they might perceive the obvious prevalence of women "patients" in advertisements in some context other than a sexual bias (6). This paper is a study of self-reported effects on psychiatrist-consumers of advertising showing possible sexual bias.

Procedure

Each of the total group of 22 psychiatrists in private practice in a middle-sized southern urban area, along with 8 hospital staff psychiatrists who have a part-time private practice, were sent questionnaires labeled "Advertising Research," along with an explanatory cover letter by the authors. This packet contained the following: 1) Xerox copies of all pages from the December 1973 issue of *The American Journal of Psychiatry* that advertised. *This paper reprinted by permission of the *American Journal of Psychiatry*, where it appeared in Vol. 131, Nov. 1974, pp. 1273-1275.

tised drugs used in treating depression, anxiety, and psychosis and that were illustrated by a photograph or drawing of a "patient"; 2) general directions for completing the forms; 3) a 12-item questionnaire, shown in full in appendix 1. The questionnaires required no signature and identified the respondent only as a man or a woman; 23 psychiatrists (20 men and 3 women) responded.

Discussion

Not surprisingly, responses indicated that 70 percent of the male psychiatrists included in the survey agreed that ads containing pictures of attractive female "patients" are more likely to attract their attention than those using male "patients." Like most intelligent consumers, the respondents perceived themselves as being aware of the advertisers' motives and methods; 45 percent felt that "female attractiveness" was the primary reason that more women than men were used in the drug ads (since the majority of physicians are men), listing such comments as: "An attractive girl in a photo certainly catches my eye," and "Drug companies, like auto dealers, know you will notice the girl in the ad first and their product second." Fifty-five percent felt that women were used as patients primarily for other reasons; respondents listed these in order of frequency: 1) "The advertisers attempt to present a typical patient; doctors see more office patients who are female than male"; 2) "It reflects a male-oriented culture where women are subservient and more vulnerable to illness"; 3) "Advertisers feel showing women as patients is less threatening and more generally acceptable to physicians."

In general, responses reflected national statistical trends on office patient population; 65 percent reported more women than men seen for evaluation and treatment. However, 77 percent indicated they did not see a higher percentage of women than men who required treatment for mental illness. This statistic may indicate that men typically do not make an initial contact with a psychiatrist until symptoms become severe and may reflect cultural differences described by one respondent: "Women feel culturally more free to seek help from all medical specialties. It is not viewed as an admission of weakness."

Seventy-four percent felt that if one knew little about psychiatry as a specialty the ads would indicate that more women than men had symptoms of mental illness requiring medication. Several respondents stated such advertising might have less effect on psychiatrists than on other physicians (who typically are exposed to the same advertising copy in other specialty journals) because psychiatrists' training is directed toward looking for underlying causes of all behavior. Approximately one-half of the respondents felt that the thinking of all physicians might be affected by seeing women portrayed as patients in the majority of advertisements. The specific effects on physicians' thinking were described in these typical comments by 45 percent of respondents: "tends to perpetuate general trend of thinking of women as weaker, more sick"; "subliminally might indicate women are crazier"; "might imprint male M.D.s with impression mental illness and femaleness go together"; "contains numerous negative subtle implications about female patient"; "might make physicians think women have predominance of mental illness without looking at underlying causes — less socially acceptable for male to have a psychiatric disorder." The remaining 55 percent indicated they felt their thinking was not influenced at all by drug ads of any type because, as several commented, "Most drug ads and information from drug companies are viewed with caution and reservations by physicians." They felt that they were also well aware that factors of cultural pressure and role expectations both influenced the higher number women seeking psychiatric help and permitted women to seek medical care in general more readily than men.

Responses appear to indicate that drug companies might achieve their ends (attracting attention of consumers) by picturing *both* a male and female "patient" in ad illustrations. If these ads are perceived as sexually biased and do influence the thinking and role perceptions of physicians, as 45 percent of our respondents believe, medical journals and other media aimed toward, and edited by, medical professionals have some responsibility toward redirection and evaluation of these influences. Even the group of respondents who felt that drug companies were merely reflecting the larger number of women seen as office patients would be unlikely to sanction, as a similar example, illustration of the nation's poor and deprived as typically black, without overt and unmistakable labeling and understanding of the social, educational, and cultural problems that result in the larger numbers of blacks being in lower socioeconomic categories.

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Appendix 1

Questionnaire Items and Responses¹

1. Do you feel that more women were used as patients in the illustrations because doctors normally treat more women than men for mental illness (neurosis, depression, psychosis)? (Yes, 48 percent; No, 52 percent)
2. Do you in your own practice normally see more women than men who must be treated for mental illness? (Yes, 70 percent; No, 30 percent)
3. Do you normally see a total of more women than men patients? (Yes, 65 percent; No, 35 percent)
4. Thinking in terms of total number of patients seen, do a higher percentage of the women you see require treatment for mental illness than the men you see? (Yes, 23 percent; No, 77 percent)
- 5a. Do you feel that more women were used in illustrations because most physicians are men, and women models would be more attractive to them? (Yes, 65 percent; No, 35 percent)
- 5b. Do you feel that was the primary reason more women than men were shown? (Yes, 45 percent; No, 55 percent)
6. Is it less anxiety provoking to you as a male, to see women used as illustrating patients?* (Yes, 26 percent; No, 74 percent)
7. If you knew little about psychiatry as a specialty, do you feel these ads would indicate to you that more women than men have symptoms of mental illness requiring medication? (Yes, 74 percent; No, 26 percent)
8. Do you feel that the ads indicate that women are somewhat more responsive to, and require more medication than, men (because of the predominance of female

- “patients” pictured) for symptoms of mental illness? (Yes, 48 percent; No, 52 percent)
9. Have you found in your own practice, that women are more responsive to, and require more medication than, men for symptoms of mental illness? (Yes, 9 percent; No, 91 percent)
 10. Do you personally feel you might notice an ad more when it uses a picture of a fairly attractive woman as a patient, than if a man had been used?*(Yes, 70 percent; No, 30 percent)
 11. Do you feel that seeing more women than men pictured as mental patients might have any effect on the thinking of physicians? (Yes, 45 percent; No, 55 percent)
 12. If your answer to question 11 was yes, would you describe some of the effects?

¹Questions followed by an asterisk were answered by men only.

WOMEN IN MEDICAL SCHOOL

SUPPORT GROUPS FOR WOMEN IN MEDICAL SCHOOL: A FIRST-YEAR PROGRAM*

Elaine Hilberman, M.D., Judy Konanc, Ph.D.,
Maria Perez-Reyes, M.D., Rosemary Hunter, M.D.,
Joan Scagnelli, Ph.D., and Shirley Sanders, Ph.D.
University of North Carolina School of Medicine
Chapel Hill, North Carolina

Abstract

This report presents a workable model for a support for first-year women medical students at the University of North Carolina School of Medicine. The students met in small groups at weekly intervals with women faculty members from the Department of Psychiatry throughout the academic year. Role conflicts which confront these young women professionals entering a "masculine" field as a minority group are described. There is an elaboration of those factors, both personal and institutional, which serve either to promote or deter conflict resolution and the acquisition of a satisfactory professional and female identity. A discussion of group formation and processes and a year-end evaluation are included. Both students and faculty assessed the program as having provided a needed and constructive setting in which to explore the problems and identities of women professionals and to develop close supportive relationships with women colleagues.

As women, faculty members, clinicians, and parents, the authors have had longstanding concerns about the conflicts which plague women as they enter medical careers and the lack of opportunity within the traditional structure of medical education for women to recognize and deal with these issues. This report describes a support system for first-year women medical students at the University of North Carolina School of Medicine as they negotiate the process of entry into medical school and establish the beginnings of a professional identity.

While some of this process is universal, there is increasing evidence to support the notion that women, by virtue of sex-role socialization patterns, as well as a minority status in medicine, have a more formidable burden of conflict resolution than do their male peers. A major barrier to a woman's achievement of excellence and commitment is the expectation that her career pattern will be identical to that of men when, in fact, the usual pattern for women includes multiple roles, dual commitments, and occasional interruptions (1). The woman who would aspire to a career and retain her femaleness is often excluded, not because of an active program to keep her out of medical school but because the inflexibility of the traditional medical curriculum is incompatible with the maintenance of dual roles (2-4).

It can be assumed that the women currently entering medical school are products of traditional sex-role socialization (5) in which femininity is equated with passivity and child bearing/rearing activities, and in which a woman's gratification of intellectual strivings is achieved only indirectly by identification with the successes of her husband and children. Notman and Nadelson (6) describe the spectrum of conflicts stemming from traditional socialization values. Entry into medical school usually occurs before issues of identity and sex role are fully resolved. The young woman student who has identified with

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a male professional may encounter difficulties in resolving her own female identity; in addition, failure to identify with a traditional woman may be perceived as a betrayal of her mother's values. Invariably, medicine is presented as a field which is incompatible with family life. Further, successful student behavior (assertiveness, competitiveness) is at odds with the usual definitions of femininity, and so men are bright, young "go-getters" while women are "pushy". The absence of nontraditional female role models is a major deterrent to resolution of these identity issues and also perpetuates and reinforces maladaptive coping mechanisms.

Several authors (6, 7) have addressed the issue of coping mechanisms in women medical students. The woman student can deny that there is any difference between herself and her male colleagues; she identifies with men and becomes "one of the boys" and, therefore, different from (and better than) most women. Alternatively, she can dispel some of her anxieties about her femaleness by adopting almost a caricature of the traditional female role, with a seductive, helpless, and dependent stance. Both of these patterns are often reinforced by male colleagues, who have had little exposure to women professionals and who allay their own anxieties by relating to women students as either "neuters" or sex objects. Another variation on these themes is for the woman student to become a "superwoman" with the goal of compulsive excellence in both career and family roles and a continual need to prove her competence in all areas.

As an alternate route the woman student may recognize the unfairness of her milieu, which puts her in an equally difficult position. Anger and frustration are prominent and may lead to significant isolation from her peers. Constructive support or the establishment of liaisons with other women students, may help in bridging the isolation and, hopefully, lead to corrective action by bringing these issues to the attention of the institution. A number of authors (5-9) suggest the importance of a support system for women students in order to provide role models and opportunities for mutual sharing and solving of problems, but the availability of such support is quite rare. In this paper the authors review the process of formation of such a support system and present an evaluation of the program by means of faculty assessment of the group process and a year-end student critique.*

Group Formation

A letter was sent to all entering women medical students in the summer of 1973 as part of their orientation packet, and an informal meeting was held with all interested women during their orientation. The following issues were identified and discussed as being potentially conflictual: scarcity of female role models in medicine, stereotypic views of women physicians and their impact on self and career definition, direct or covert communication of sex role bias by male peers of faculty, family-career conflict and the acquisition of dual roles, intensification of role conflicts by the inflexible medical school curriculum, and definition of medicine as a "masculine" field. The women students were then given the option of meeting weekly in small informal groups. The 18 first-year women participants (of a total of 23 women in the first-year class) and one second-year woman student were assigned randomly to one of three groups, with two faculty women in each group. Groups met during the day for one to two hours, not only to avoid conflict with nightly family responsibilities but also because supportive services for minority students were felt to be an essential, legitimate part of medical education. The six authors (the participating faculty) met separately at weekly intervals to detail group process via written process notes and recall. All faculty were from the Department of Psychiatry, the only department in the medical school with a sizable female membership.

Faculty Assessment

From the beginning each group assumed its own distinct personality and tempo. Group A was the most reticent, with the majority of members experiencing significant personal and interpersonal conflict. Group B was a verbally expressive, lively, and highly competitive group in which the minority of more reserved members tended to be ignored. Group C evolved more slowly from a small irregularly attended group to a larger regular meeting of equally involved members. There were many similarities and some differences in the evolution of group relationships and content among the three groups, and what follows is the shared process of these groups.

Early meetings were characterized by high levels of anxiety, as each group went through a "getting acquainted" phase. Members asked about family backgrounds, motives for choosing a medical career, and reactions to the availability of a support group. There was a wide variation in self-assessment; some felt "special" and bright, while others more nervously labeled themselves as different, weird, and neuter, in comparison with non-professional women as well as their male colleagues. Group structure and goals at that time were undefined.

For each group, a sense of cohesiveness evolved in response to a different "challenge." Two members in Group B with previous experiences in psychotherapy promoted an intimate, insight-oriented group model which was accepted and led to an early sense of cohesiveness and purpose. Group A united in anger towards both an unsupportive and competitive group member and a lecturer with a gross sex bias. The members took action by way of verbally protesting the lecturer's behavior, sensing their common reaction to the other member and gradually moving to focus on group goals. At an open meeting of all groups, initiated and persuasively led by Group B six weeks into the year, Group C was confronted with the possibility of dissolving itself. In reaction to the threat of dissolution, Group C coalesced as a group.

By the end of the second month all groups began exploring a number of identity issues. They openly wondered why they chose medical careers. Few felt that they did so through identification with their mothers. In one group a majority of the participants felt that their career decisions reflected a reaction to the perceived emptiness of their mothers' roles. While families were often supportive of their choices, the mothers seemed to indicate that their daughters must choose between career and marriage: "Don't marry. Do something with your life." "Don't waste your life. You are too talented to give up a career for marriage." A recurring and collective fantasy emerged of what it would be like to be a medical student or physician. There would be an end to bright clothing, laughing, dancing, romantic pursuits, and emotional expressiveness, all of which would be replaced by "serious thinking" and a total devotion to medicine. One student described herself as a "dropout from femininity." In short, many members believed they were supposed to emulate the stereotypic cold, rational male, with a medical career and femaleness fearfully viewed as mutually exclusive.

A prominent and allied identity issue concerned the image of the omniscient, super physician the women students were to become versus the frequently overwhelmed, fallible individuals they felt themselves to be. Again, the women described themselves as being different from their male peers, but now the difference was given an openly negative connotation. During this early period, the leaders collected data for an evaluation of the program, and it was apparent that some of the students felt quite threatened; that is, they feared the test results would show that they had no business being in medical school. It was clear that they had an idealized image of what physicians are like from previous life experiences. Two aspects of that image, to be male and to be omniscient, would never be

possible; and over the year this image was adaptively revised.

Acknowledgment that professional identities were shaky led to increased anxiety levels and a strengthening of group cohesiveness. Focus shifted to male-female relationships, with feelings and conflicts concerning marriage being perhaps the most problematic. There was ample evidence that the students defined themselves as deviant females because of professional aspirations, and they adopted various modes of compensation in their relationships with men. Many students assumed that if they behaved naturally, they would be perceived as threatening and unfeminine. Thus, they became perfect wives who maintained all domestic responsibilities and kept medical studies secondary and remote from their relationships. This obligation to play the traditional passive role in relationships with men resulted in a large reservoir of chronic anger, guilt, and conflict, both within themselves and in their relationships with their men. Single women experienced similar feelings and, in addition, had special problems with respect to how to meet men. They had a minimum of free time to meet and date men outside of school and were in reality quite isolated. All of the women were often resentful that their male peers regarded them only as buddies or laboratory partners rather than as women and equal professionals.

Feelings of isolation were conspicuous in all groups for all women, particularly in the early months; and these seemed to be a partial reflection of the loss of emotional support by family and friends as a result of the move to the medical school community. Opportunities to make new friends were limited. Except for the groups, the women had little chance to talk with other women medical students; and male classmates were ambivalently regarded. A more troublesome source of isolation stemmed from their minority status in the medical school. Isolation was intensified by sporadic incidents in which male faculty members made derogatory remarks and jokes demeaning both women physicians and women patients. Students used the groups to ventilate their anger about such incidents, and eventually one group directly confronted a professor about his behavior. Male peers did not offer much support to the women at these times, a fact which painfully increased their sense of isolation and difference.

Special problems with identity issues were evidenced by the black women in each group, who were contending with the double pressures of being both black and female. There was a tendency for some black members to be less active and absent more as the year progressed, although other black students moved from listening to active participation.

All groups shifted in focus following the semester break, each assuming a different direction. Group B seemed to feel more interpersonal distance, with discussions centering on impersonal, global concerns such as death and dying and government-financed health care. Group C, in contrast, was now a very cohesive unit which began to handle more personal problems in its meetings. That group initiated a social gathering at the home of a staff member; this both reflected and fostered the growing intimacy between students and staff members. Group A focused on themes of competitiveness, especially among women.

Each group dealt with feelings about being female, with increased recognition of the ways in which women have devalued themselves and other women by virtue of judging females by male standards and the male company they keep. Group members explored a variety of possible roles for women and in doing so reflected again on their own backgrounds, the roles of their mothers, and the marriages of their parents. There were widely differing views of marriage and parenting, with considerable discussion about the relationship between an unhappy role and inadequate parenting. The faculty women,

who represented a wide spectrum of life-styles and interests, functioned prominently as role models during this time of exploring ways to combine personal and professional goals.

The students' new experience with patients (taped interviews in the second semester) prompted reworking of their professional identities. They expressed concerns about their acceptance by patients, particularly male patients, with a focus on anticipated reactions of male patients to them as women physicians, for example, embarrassment about physical examinations, avoidance of sexual concerns, or seductive behavior. In defining their probable roles in relation to patients, the students were also trying to derive their own roles as individuals separate from that of being physicians. There was a strong wish to maintain a personal identity with significant relationships and interests outside of medicine. They hoped to care for others and for themselves without either an impersonal, selfishly materialistic emphasis or total self-denial.

Toward the end of the academic year, the women seemed to feel more comfortable about being both female and competent. In contrast to earlier discussions which focused on internal and personal conflicts impeding identity development, attention was now turned to institutional barriers. As an example, the rigid third-year schedule was seen as preventing adequate parenting. Usually, student requests for schedule modifications were handled on an individual basis with each clinical service, thus leaving each student feeling guilty about her special favor and resented by her colleagues. Many of the first-year women, and this time some men, formally suggested to the administration that a restructured more flexible curriculum would be beneficial to both sexes.

As final examinations approached, anxiety levels rose within the groups, and attendance for the first time began to wane. Groups with more competitive members perceived discussion of these pressures as escalating rather than decreasing their anxiety. Despite this, the *esprit de corps* remained. Members wished the groups might continue the following year and expressed sadness about ending. A myriad of personal questions directed to the leaders seemed to reflect the intense need for role models and the desire for greater, continuing closeness. The women organized a postexamination social gathering for the final termination of two of the groups. The affectionate congratulations of one another for having passed the examinations verified the development of close personal friendships and the women's increased comfort in their roles as medical students. The groups had provided an experience in closeness and female support which now continued outside the groups. The faculty leaders, too, felt increased closeness as well as considerable appreciation and respect for these young women who chose, despite sizable obstacles, to become physicians.

Role definition of the faculty leaders was a complex and problematic issue. There was lengthy discussion about how the leaders might relate to the groups with the options including the roles of the therapist, faculty member, role model, and peer. In retrospect, it appeared that the leaders were called on to be all of these at different times, depending on each group's need. In contrast to the authors' usual role as therapist, it seemed most important to be themselves in the groups so that the students would have an opportunity to share the leaders' histories, identities, and modes of adjustment. At times, however, the leaders did function more as therapists in dealing with intragroup and intrapsychic dynamics. Faculty roles became more prominent in confronting situations which required administrative action. The essential and unique feature of the groups, however, seemed to be the opportunity to share personal feelings and conflicts of every sort in an empathetic gathering of students and faculty. Attention had been focused on one's person and not one's performance.

Certain unavoidable problems in the project design were regretted. For example, although the need for black role models was obvious, there were none in the medical school. It is relevant that in the subsequent academic year the black women themselves requested and obtained funds to bring in black women physicians as speakers. Similarly, the participation of women physicians from other specialties would have been welcomed and would have provided a richer matrix of role models.

Student Assessment

All group members anonymously completed a specially designed evaluation form at the end of the academic year. The two most important initial reasons given for joining the groups involved exploration of the problems and identities of professional women. In retrospect, the students rated the groups as only moderately helpful in meeting these original expectations and rated getting to know and becoming close friends with women classmates as the two most helpful functions of the group. This composite perception by the women reflected an apparent shift in goals that evolved with the development of group needs and experiences. This shift is reflected in the following statements by two students:

It seemed appropriate to become more personal in our conversations after getting to know each other better and getting to be a stable group.

I made two shifts. In the beginning I was mainly interested in having some outlet for personal feelings and problems. Later I realized that the most important thing for me in the group was developing closer relationships with other women. I've developed some strong friendships partly because of group. Without the group I might not have taken the time.

Despite the apparent modification of group goals, however, the original goals appeared to remain important, and the group was considered to be moderately helpful to the majority of group members in their understanding of personal identities and the problems and identities of women professionals. It is also probable that the student reports of finding the group highly important as a means for developing closeness with other women classmates represents another more indirect continuing process which enables women to help each other establish a professional identity.

All of the women had well defined reasons for participating in the group. No one joined simply to "follow the crowd." In addition, social activism was neither highly sought after nor strongly promoted within the groups. A majority of the women indicated that they were satisfied with the frequency and length of the meetings and the attendance and participation of classmates and faculty. They recommended mixing the groups by sex, minority representation, advanced and incoming students, and nonpsychiatric faculty. They further indicated that more structure might have helped in group discussions. On the whole, however, the students expressed satisfaction with the supportive nature of the groups and a wish that such a program be provided for a new first-year students as well as continued for themselves.

Conclusions

The students who participated in the first-year program of support groups explored an impressive array of issues related to being women and physicians. These included relationships with parents, colleagues, patients, and significant men and women in their lives. There was increasing awareness of internal (self-concept) and external (institutional) obstacles to the development of a satisfactory professional identity and resolution of role conflict. Their feelings of isolation in medical school, anxiety about course demands, and anger over sex discrimination were aired, shared, and in part resolved, at times by establishing new friendships, discussing mutual fears, or actively protesting biased behavior. Professional identity was developed and enhanced. The students expressed overall satisfaction with the groups and special appreciation for the support and closeness provided. They were enthusiastic about getting to know and befriend other women classmates and sharing in the development of personal and professional identity. It is likely that their established friendships with each other will continue to be mutually gratifying and helpful.

Women who enter medical school appear to be bright, capable individuals who experience considerable professional and personal pressures as they adjust to the process of medical school education. They must deal with issues of universal concern to medical students, for example, the doctor-patient relationship, and death and dying, and those of special concern to women, for example, heterosexual roles, and achievement. Support groups seem to provide a needed, constructive setting within which exploration of personal and professional concerns can occur. Women at other medical schools might profit by involvement in comparable groups.

It should, however, be firmly stated that role conflicts are not peculiar to women professionals. Male classmates of the women group participants frequently expressed their own need for a similar program. The apparent absence of family-career conflict in men is attributed to social norms, in which the traditional male resolves or denies such conflict by choosing one role, that of the professional, thereby burdening his wife with the major responsibility for maintaining a home, family, children, and marriage. Statistics relevant to the personal lives of all physicians, for example, suicide rate, alcoholism, drug abuse, and divorce, suggest that support groups for both men and women physicians in

training might be an important preventive health measure. As more women aspire to and attain an equal status with men and enter into occupations and professions outside the home, male physicians are likely to experience many of the difficulties presently encountered by women including increased pressure on men to assume more responsibility for home and child-rearing activities. Hopefully, more medical schools in the future will provide support groups for all students, men and women alike.

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*A more formal program evaluation by means of preparticipation testing of both group members and control group at a neighboring medical school failed to find significant differences. Future efforts might be directed toward a study of changes in the woman medical student's image of female physicians and of herself as a physician, as well as the value of women role models. Further information is available from the authors.

IMPACT OF A DISTRICT BRANCH TASK FORCE ON WOMEN*

Elaine Hiberman, M.D.,
Maria Gisp rt, M.D.,
University of North Carolina
School of Medicine
Chapel Hill, N.C.

Jackie Harper
North Carolina Neuropsychiatric Association
Raleigh, N.C.

A questionnaire sent to all women psychiatrists and trainees in North Carolina as part of the development of a district branch Task Force on Women indicated that institutional sexism affects the careers of many of the respondents. Problems of family-professional role conflicts were especially pronounced in residents and faculty women. Survey findings have resulted in recommendations in the areas of education, communication, and increasing women's participation in task force and district branch activities. The authors feel that such task forces provide a much needed network of supportive relationships for women psychiatrists and raise the consciousness of the district branch regarding women's issues.

In 1972 the American Psychiatric Association created a Task Force on Women, which was charged with exploring the concerns of women in psychiatry and the relationship of psychiatry to the problems of women in general (1). These goals were accomplished in several ways, including the establishment of informal communication networks for women psychiatrists at the grassroots level and programs about women at annual meetings of the Association. The strong and visible presence of the APA Task Force on Women provided invaluable support to women psychiatrists around the country, who often had been quite isolated from each other and from their male colleagues. One impact of this support system was the spontaneous appearance of local task forces on women as part of district branch activities. A panel at the 1975 annual meeting (2) described the development of a variety of local task forces on women, which differed as a function of geographic location, constituency, perceived needs, and level of feminist consciousness. Perhaps the one common feature was that the leadership of each task force was always shared by two women, who were able to give each other the necessary support to confront the male-dominated district branches. This report will describe the work and impact of one such local task force in the 2 years since its inception.

The North Carolina Neuropsychiatric Association (NCNPA) is a district branch of the American Psychiatric Association and draws its membership from the entire state. The association has a total membership of about 300, 10% of whom are women. The members are separated by geographic distances as well as a wide spectrum of professional interests. There are semiannual meetings; spring meetings are poorly attended, and fall meetings are moderately well attended by academicians or practitioners, depending on program content. Partly because the leadership of the NCNPA is male and appointments to committees are usually made by personal contacts, the executive and policy making bodies of the association have not included women, and formal programs have reflected traditional interests and values. Several women stated that they had not been asked to participate and hesitated to volunteer because the all-male composition of committees

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made them feel unwelcome. Further, personal communications to task force members have revealed that women psychiatrists eligible for APA fellowship status have been dissuaded from applying or have been given weak recommendations at the district branch level.

In May 1974, the NCNPA created a Task Force on Women as the result of a direct request made by the two women psychiatrists who subsequently chaired the task force. Once formal task force status was conferred, it was decided that a survey of women psychiatrists in North Carolina should precede both expansion and definition of goals for the task force. The primary purpose of this paper is to present the findings of this survey and their implications.

Method

The survey was accomplished by means of a lengthy questionnaire which incorporated material used in a questionnaire developed by the APA Task Force on Women. The questionnaire was mailed to all women psychiatrists and psychiatrists-in-training in the state, regardless of membership status in the NCNPA. One section of the questionnaire dealt with general issues relevant to women and was sent to the entire sample, while other sections were specifically designed for women in training, private practice, on university faculties, or employed in hospitals or mental health centers.

Results

Of the 50 questionnaires mailed, 25 were completed and returned. A summary of the responses follows.

Demographic Data

The 25 respondents were distributed by professional categories as follows: private practice, N = 8; hospitals or mental health centers, N = 3; trainees, N = 8; and faculty members, N = 6. Response rates were 60% for women employed in academia and in hospitals or mental health centers, 50% for private practitioners, and 42% for trainees. The respondents ranged in age from 26 to 77, with a fairly even distribution from the mid-twenties to sixty. Sixty-four percent were married and 36% were single, divorced, or widowed. Respondents had a total of 45 children, with a range of 0-4. Patterns of early childrearing practices of the 17 women with children varied with the age of the respondent. Younger women reported taking less than 6 months off for childbearing and child rearing, while those over the age of 45 had spent an average of 6-8 years away from their careers. Sixty-four percent of the sample had full- or part-time household help.

Seventy-two percent of the sample were working full-time and 28% part-time. Full-time work was defined by the respondents as 36-65 hours a week and part-time work as 10-35 hours a week. Respondents reporting part-time work included all settings other than academia. A broad spectrum of professional interests was reported, with a special interest in children and adolescents mentioned frequently by faculty women and trainees. Few women described any serious research interests. Specialty training was reported by 44% of the sample, but only 25% were Board certified. Failure to take the Boards was usually attributed to insufficient time for preparation as a result of dual commitments to family and career. The respondents tended to be joiners of professional organizations: 76% belonged to the NCNPA/APA, 48% to the American Medical Association, and 36% to the American Medical Women's Association.

Training

The majority of the respondents believed that seminars on women's issues, women's studies, courses, and a format to deal with family-career conflicts are important parts of psychiatric education. Responses indicated that these perceived needs had not been met in respondents' training in the past and continue to be unavailable for the present group of trainees. It is interesting that 60% indicated that they had adequate supervision and teaching by women psychiatrists and 88% believed that there were women available with whom they could share personal concerns about their roles. However, more than half of these affirmative responses were qualified; for example, respondents noted that there was no time set aside in program priorities to deal with role conflict or that only nonphysician women role models were available. Also, one faculty woman was mentioned by several respondents as being the only woman available to trainees.

Patient Care

Questions in the patient-care section dealt with the availability of women therapists, of therapists sensitive to role conflict and to assumptions about mental health based on sex-role stereotypes, of crisis intervention for rape victims, counseling for problem pregnancies, abortion counseling, support for decisions to terminate marriage, and nonjudgmental treatment of lesbians who do not wish to change their sexual preference. The data were strikingly inconsistent—for example, several women who indicated that they were the only women therapists in their geographic areas or academic institutions also believed that availability of women therapists was adequate. Some women did not think it was important for therapists to be sensitive to role conflict. One woman was unaware of the existence of stereotypic assumptions about mental health based on sex role. Almost two-thirds indicated that there had been no discussion in their work settings about issues regarding the treatment of women as patients. The responses suggest that although there is a growing awareness of changes in women's roles in contemporary society, women in psychiatry are not as sensitive as they might be to the needs of women patients.

Women's Movement

Questions in this section were related to impressions of and degree of involvement in the women's movement. Eighty percent expressed favorable feelings about the women's movement. Of this group, however, only 30% described strongly favorable feelings, while 70% indicated milder interest. Uncertainty about the goals of the movement was illustrated by a respondent who was favorable toward it but was "more interested in economic discrimination." One of the less interested respondents commented, "Since I personally never had problems in these areas, it seems that time is better spent in developing one's professional skills." The majority were aware of the concept of consciousness-raising groups, and 24% indicated that they refer patients to such groups. Most favored passage of the Equal Rights Amendment; a few were ambivalent. Although many respondents joined professional organizations, they tended to be nonjoiners of organizations related to the women's movement. The high percentage of positive responses to the women's movement may reflect a skewed sample. We assume that women who took time to complete the questionnaire had more sensitivity to issues of sex role stereotyping and sex discrimination than nonrespondents.

District Branch Activities

Seventy-two percent of the respondents thought that the NCNPA should take a formal, affirmative position with regard to the Equal Rights Amendment, which was at that time

being debated in the state legislature. Although most respondents were aware that there have been no women in important policy making or executive positions in the NCNPA, 56% were not interested in increasing their activities in a leadership position, 24% expressed an interest in doing so, and 20% were undecided. Less than half believed that the NCNPA programs adequately reflected concerns of women psychiatrists and problems specific to women patients. They suggested a variety of themes for future programs, including women in residency training, sex roles and children, early training to help women keep options open in future roles, treatment of women patients, lesbianism, and rape. Despite respondents' minimal interest in increasing their participation in district branch activities, over half of them said they would take part in a panel or program about women. The majority thought the existence of a Task Force on Women was relevant and necessary, but only 28% indicated willingness to participate actively.

Individual Work Settings

The following section summarizes responses of women regarding their various professional settings.

1. Private practice. Four of the private practitioners were in individual practice and 4 were in group practice. Their primary activities were individual psychotherapy and consultation. However, all 8 had teaching responsibilities, some of them quite substantial, at nearby teaching institutions. They expressed satisfaction with relationships with male colleagues, whom they described as supportive, and with quality and quantity of patient referrals. Only 3 of these women indicated that they had discussed attitudes about working women with their groups before joining. In general, they had fewer complaints and indicated less conflict about roles than did women in the three other settings. Their responses suggested that they had chosen the private practice setting in order to increase flexibility of scheduling and to facilitate family commitments.

2. Hospitals or mental health centers. One of the 3 respondents who worked in this type of setting described overt discrimination in hiring practices, promotions, and salaries and characterized her relationship with male colleagues as "indifferent." The other 2 women described their status as "equal among equals," with no institutional practices discouraging women, but they also reported no provisions other than paid leave based on accumulated leave time to deal with childbearing and child rearing, nor were there special arrangements for night calls, weekends, or vacations for staff members with families. No ombudsperson was available to these women in cases of perceived sex discrimination, and there was no grievance procedure available to 2 of these 3 women. All 3 respondents in this category indicated that there had been no conferences or seminars on the psychology of women, sex roles, etc., at their facilities. While it is not possible to draw conclusions based on a sample of 3 respondents, the lack of flexibility in procedures related to childbearing and child rearing and on-call scheduling indicates subtle institutional sexism of which some women were unaware.

3. Trainees. The 8 trainees described their residency training experiences with frustration and cynicism. They were all in programs with few other women and knew very little about affirmative action programs, recruitment policies, child care arrangements, and grievance procedures in their programs. There were no special arrangements for night call, and part-time training opportunities were difficult to arrange. Provisions for childbirth and child care were generally handled on an individual basis, usually involving paid leave based on accumulated sick or vacation time, with no credit for time in residency. In contrast, in one program there was a formal policy whereby short military leave (e.g., 2

weeks a year in the reserves or the National Guard) was fully paid, did not come out of accumulated leave, and did not lengthen residency training time.

Impact of a District Branch Task Force on Women part 2

Most of these respondents had no ombudsperson available to deal with any perceived sex discrimination, and 7 of the 8 were not aware of any formal grievance procedure. The one resident who did report the existence of a grievance procedure summarized it as follows: "You end up going to the chairman and if he agrees, you may succeed. If he doesn't, that's it." Financial issues were mentioned often. One woman stated, "Salaries are too low to permit adequate household help to make life bearable while in training." All but one respondent indicated that faculty women were not adequately represented in positions of power at their various institutions.

The information we gained about the content of training was equally disheartening. Most residents reported that less than 10% of their course work, seminars, and supervision was conducted by women, and courses and seminars about women were strikingly absent (e.g., "minimal amount—one seminar during first year of residency"; "adherence to old Freudian psychology—just lip service to treating women as people rather than as castrated men").

Some other comments by women residents included the following:

I have felt a double standard in my training. If I work extremely hard, I do not have to worry about overt discrimination from the faculty. There is infantilization of women by some and a true lack of understanding by most.

Most (peers) pay little attention to me. They seem to relate to each other as boys only, i.e., sports and poker.

(Relationships with peers) good at present, with some distance and difficulties around competition . . . many feelings about women in their past placed on me in concentrated form and very unpleasant.

4. Faculty. The 6 faculty respondents were quite similar to the trainees in their expressions of frustration, but they had more specific information available to document seemingly pervasive patterns of discrimination and isolation. Personal contacts—the "buddy system"—seemed to be the prevalent mode of faculty recruitment, with 4 of these 6 women indicating that search committees rarely included women and that open advertising is rare. Only one woman had access to salary information, and there was considerable uncertainty about how these respondents' salaries correlated with those of male peers. One woman reported having been "openly told I would receive less because I was married to another faculty member." Part-time faculty appointments were rare and did not lead to eventual tenure. Provisions for childbearing and child rearing were uncertain, and it is relevant that few faculty women had small children. None of the faculty women indicated the availability of an ombudsperson or of an adequate grievance mechanism for issues of sex discrimination.

Formal discussion about the status of women psychiatrists was reported to be infrequent. In contrast to the women residents' reports of the powerlessness of female faculty members, the women faculty perceived themselves to be adequately represented in positions of power. Course work and seminars specifically on women's issues were absent; such material was only brought up indirectly in an occasional seminar.

Faculty women made the following comments about problems in their departments: "Integration of professional life with family and/or private life has presented problems for almost every woman in differing degrees." "Lack of power, isolation of women from male faculty, and rigid expectations that a successful woman must act like a man to survive in

the department." "Not enough time; academic pressure towards productivity and performance. Women who are offered positions only stay from one to four years because of the stress of the academic environment."

Task Force Recommendations

A summary of questionnaire results was presented to the membership at the fall meeting of the NCNPA in October 1974, and the following formal recommendations were offered:

1. Despite the burdens of dual roles, women must become active on their own behalf, as advocates for women patients, and as role models for men and women trainees.

2. The NCNPA has a responsibility to become sensitized to the needs of women members in the areas of both educational programs and appointments. A general portion of the 1975 fall meeting might appropriately be devoted to a theme of particular relevance to women in psychiatry.

The report and recommendations were surprisingly well received, partially because this is an area of growing interest. In addition, the organization was facing an energy crisis in which apathy and insufficient commitment to maintain the organization prevailed. The Task Force on Women was proposed and perceived as one mechanism for bringing a new level of interest, activity, and membership to the entire organization. The final report of the American Psychiatric Association Task Force on Women recommending a standing committee on women was also introduced and added credibility to the local task force report. As part of the fall meeting, the NCNPA task force held an open meeting for women members, at which time our membership was expanded.

Implementation and Impact

The following section summarizes the work of the Task Force on Women to implement their recommendations.

1. *Participation.* A mailing was sent to all women members, asking about their interest and availability in serving on the various committees and components of the NCNPA, and the responses were forwarded to the district branch President. Questionnaire responses had indicated that few women would accept an appointment, so it was particularly gratifying that almost half of the female membership agreed to serve on committees. We believe that the questionnaire itself may have served an important consciousness-raising function. One of the cochairpersons of the task force was elected to the Executive Council of the district branch and was the first woman to serve on that council in many years. Women have subsequently been elected to several other positions on the Executive Council and are now represented on almost all committees of the NCNPA.

2. *Communication.* Because the district branch encompasses the entire state, meetings have not seemed a workable vehicle for communication, and the NCNPA newsletter has been used to disseminate information about women to the membership. There was, for example, an entire page on the Equal Rights Amendment, including a statement of APA's position, which led many members to contact their legislators.

3. *Support.* Although few of the women psychiatrists have expressed interest in an ongoing consciousness-raising group, task force meetings always seem to go far beyond the state agenda; personal and professional conflicts are often presented with urgency and a flood of relief. This phenomenon documents the extent to which these women have been isolated from their peers and their need for support from women colleagues. For example, several articulate and talented women who were invited to participate in the

NCNPA fall meeting refused because they felt they had little of value to communicate to their colleagues. It is anticipated that continuing contacts among North Carolina's women psychiatrists will raise self-esteem as well as consciousness.

4. *Education.* The idea that a program about women was relevant and appropriate was accepted, and such a program took place at the 1975 fall meeting of the NCNPA. Fifteen enthusiastic women participated in a series of brainstorming meetings which resulted in more than enough material for a one-week program. The one-day program was entitled "Changing Images of Women" and focused on the concerns of professional women and the mental health needs of women patients. Issues about men's roles and the impact on men of the changing roles of women were also addressed. Although there is recognition that women psychiatrists have dual roles as professionals and wives and/or mothers, there has not yet been a full awareness of men psychiatrists' dual roles as professionals and husbands and/or fathers. Personal communication with male colleagues confirm that men also experience difficulty with time demands and role conflict.

The effectiveness of the task force was documented by the responsiveness of the NCNPA membership to the 1975 annual program. Full committee status was granted, with expansion of the Committee on Women to 15 members, including representation by spouses. The one-day program included formal presentations by women medical students (3), women as residents in psychiatry (4, 5), psychotherapists' biases toward women (6) and research considerations by and about women (7). The evening presentation by a male historian (8) utilized a multimedia approach to describe the history and implications of the male sex-role stereotype and to evoke an affective response. The impact of the program was quite dramatic; both men and women psychiatrists and their spouses reconsidered their own roles as family members, parents, and professionals with thoughtfulness and poignancy.

In retrospect, we have theorized that the combination of cognitive input about women and the very evident cohesiveness and camaraderie shared by the women probably resulted in anxiety and a sense of isolation among the men, and the presentation about men gave them a voice with which to speak eloquently for themselves. Expressions of sadness and grief were universal as they talked about the pressures to be successful and the resulting estrangements from their families, especially their children. The meeting ended on a hopeful note, with considerable expressions of relief that there is more than one way to be a man or woman.

Discussion

It is our impression that institutional sexism exists and directly affects the lives and careers of women psychiatrists in North Carolina, with the possible exception of those who choose private practice. Even in that setting, there are some women who would have preferred a major teaching role but found it to be incompatible with other responsibilities. Some women were aware of the institutional obstacles; others were not. Thus some respondents expressed satisfaction with their work settings while describing barriers to the full participation of women professionals. Women with young children seemed particularly sensitive to these deterrents, probably because younger respondents are more aware of social change and also face the realities of dual roles. One practitioner remarked,

Those I know with no children express satisfaction and declare an absence of problems. Younger women have expressed stress problems pertaining either to husbands or children relative to the quantity of time together and deep concerns about failures of backup help with children.

Very few of the significant changes in the role and status of women throughout our society are reflected in current psychiatric education and training. Traditional values prevail, and there is little opportunity to discuss contemporary theories about the psychology of women, more appropriate treatment modalities for women patients, research efforts, and the role conflicts of women professionals. Role models for trainees continue to be unavailable because there are so few women in academic careers. Indeed, women in academia, both as faculty members and trainees, seem to be the most troubled about their families. As long as academic and professional requirements are presented in terms of male norms (e.g., the women respondents described part-time employment as 35 hours a week and full-time as 65 hours), women professionals will not be available as teachers, leaders, and role models.

Very few of the women who were sensitive to the issues we have discussed were participating in activities related to women, either in a professional role or as members of their communities, and few were actively involved with the district branch. The responses to a question about what these professional women believed were their most important sources of personal gratification are relevant to their tendency to be nonjoiners and non-activists regarding women's issues: career and family were considered equally important, with over half of the respondents indicating (in this work-related questionnaire) that family came first. The tendency of the respondents to be nonparticipants may be in part a reflection of lack of awareness of the issues, but the reality is that time is at a premium with career and family responsibilities leaving little energy for other activities.

Conclusions

The experience of the questionnaire and the existence of a visible and vocal group of women has served to raise consciousness among NCNPA membership that women's issues, whether they relate to the role and status of women professionals, the treatment of women patients, or legislation determining social policy, are the legitimate and rightful concern of psychiatrists. We would like to reemphasize the fact that our local Task Force on Women would not have been possible without the strong leadership, encouragement and support of the APA Task Force on Women.

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UNCONSCIOUS BELIEFS ABOUT WOMEN AFFECTING PSYCHOTHERAPY*

Teresa Bernardez-Bonesatti, M.D.
College of Human Medicine
Michigan State University
Lansing, Michigan

Although professional therapists, by virtue of their experience and their training are more apt to hold equalitarian views of the sexes than the general public, they behave towards women patients in ways that betray the existence of biased beliefs of female role and behavior. Therapists and patients alike cooperated in holding similar culture-syntonic assumptions about the female and in preserving the restrictions resulting from them. Although therapists do not deny the coercive effect of cultural stereotypes on their patients' behavior, this factor is often ignored when it comes to implementation of therapeutic programs. It is in their actual behavior with patients, that many therapists—skilled and inexperienced alike—reveal their biases about women (Krause, 1971; Mintz, 1974). The therapist reacts in a reflex-like, stereotypical manner to behaviors that are approved or expected by the culture, even when the therapist consciously believes that such expectations are anachronistic and not conducive to psychological growth. This dissociation between theoretical support for role change and actual therapeutic conduct, may be explained by the fact that unconscious beliefs remain discrepant from and unaltered by those beliefs the therapist holds consciously. The strong affective charge of those unconscious beliefs is the factor that often leads to the discovery of those biases in psychotherapy and their exploration in supervision. This has been the case in my own work with patients and in the work of therapists I supervised and trained. What follows is the result of that experience as well as observations of the work of many colleagues.

First, I will present the most common instances of therapists' reactions and interventions that betray prejudicial views of women and that interfere with the optimal growth of the patient.

Openly hostile behavior or a domineering attitude in women patients meets a different reception from the therapist than in men patients. Strong moral repudiation is often the therapist's reaction, which is usually restrained in front of the patient but permitted more free rein in the consultant's or supervisors office. The therapist often derides the patient's behavior and sometimes the patient herself with stereotypical terms such as "castrating," "destructive," "competitive," etc. The therapist appears less interested in understanding the patient's response in this circumstance than at other times, despite the fact that his understanding of the patient's attitude is limited. This reaction tends to correlate highly with a certain therapeutic behavior: in the therapy hour, the therapist uses "interpretations" of the patient's behaviors that tend to accentuate guilt by characterizing her and her purposes as destructive, competitive or envious without any attempt to state nor understand the defensive aspects of the behavior. Neither any realistic determinants of her anger nor any positive function that the behavior may have served to the patient is presented. Essentially the intervention is destined to the suppression of a behavior the therapist disapproves of, it is punitive since its main purpose is its disappearance through the inducement of guilt and is devoided of any redeeming qualities. In instances such as this, the therapist is covertly disapproving of the patient's behavior while explicitly acting as if he was understanding her. Such contradictory

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behavior is worsened further by giving explanations for the patient's behavior which are inaccurate and incomplete, restricted to negative and destructive meanings and consequently less likely to induce reflection or understanding on the patient's part.

When therapists discussed their reaction, they admitted to rather strong feelings of revulsion and disapproval that concealed equally strong fears of being subjugated and injured by a powerful female. The exploration of these reactions inevitably brought to light the therapist's concern over the destructiveness of the female and the utter vulnerability of the male to that power. Although I have less experience with female therapists in regular supervision, it is my observation that they react with similar disapproval, particularly if a man is the target of the patient's hostility. Concern for the protection of the male is aroused, in ways similar to the male therapist's, but in addition, the female therapist might struggle to set herself apart from any possible identification with the female patient. The fear of the female therapist is to react similarly to the patient and lose restraints on her anger.

The expectation of patients' adherence to sexual roles stereotypes and the therapist's strong reactions when such adherence is defied, are clearly observed in family therapy sessions. This is particularly so when the marital partners defy the conventional expectations and the female "runs over" her submissive mate, or when the wife abandons husband and children. In the first example, the male patient tends to arouse scorn in the therapist while this is not the response elicited by the same behavior in the female. The "domineering" wife meets the opposite response. She runs the risk of not being helped to be more assertive of her own needs (a deficiency frequently masked by her apparent demandingness). On the other hand, the submissive husband is likely to receive training in the very behavior the therapist disapproves of when the wife exercises it. In the case of the runaway wife, the therapist's reaction of disapproval to what is perceived as maternal rejection is so strong and inflexible that it requires continuous examination to prevent it from interfering with the therapeutic process. In the above examples it is possible to conjecture that the notion that the female is frail and vulnerable and requires the protection of the male has been born of the necessity to reverse the dreaded instance in which the vulnerable male is at the mercy of a powerfully destructive female. The existence of this phantasy is supported by *the reactions of male therapists to all female groups*. A few years ago I decided to form therapeutic groups of women to find out if they were more useful than mixed groups to break down stereotypes and to help women with their conflicts around aggression and autonomy. To my surprise, the reactions of many of my colleagues were skeptical and negative. They spoke of the "dangers" of such groups and expressed concerns ranging from generating increasing alienation between the sexes to encouraging a paranoid stance in women which would place all responsibility for their inadequacies on men and would prevent them from exploring their own victimization. The idea of women groups appeared to bring to mind the spectre of women who would turn out domineering and angry and who would find it easier to turn to revenge upon men. My suggestion is that the therapists saw those dangers because they were supporting the idea (although repudiating it consciously) that women have been "kept down", relegated to devalued positions and restricted in their choices and that they live under this tyranny with resentment, that if "liberated" they would feel fully justified in imposing upon men similar treatment and in so doing they would be acting in identification with the aggressor.

If the dread of unleashed female destructiveness is inferred in instances of therapists' responses to female aggressive behavior, the defense invoked to prevent it is observable in *the behavior of therapists with compliant, submissive and self-effacing female*

patients. The therapeutic errors here are more often those of omission. Therapists do not confront, question or inquire enough about these instances, which although clearly pathological are sytonic with cultural expectations of appropriate female behavior and the "norm" for female persons. These are the most common errors of therapeutic judgment and are frequently responsible for only "moderately successful" treatment outcomes. The therapist covertly encourages submissive behavior for fear of its opposite: a challenging and independent stance.

The therapist thus ignores important aspects of the patient's dependency and submissiveness in the patient's life as well as in the therapeutic situation and yet reacts with surprise when in the termination phase the patients presents him with continuous conflict, reversal of therapeutic gains and regressive behavior, which, unlike the temporary reaction to termination, does not subside.

All of these examples point to an underlying fear of female destructiveness. Lederer (1968) has commented on the avoidance of such an issue in the literature while Rheingold (1964) very explicitly articulates the unconscious belief in maternal destructiveness and its result in the dread of woman for both sexes. This author, however, assumes that the belief is reality-based, that it is inherent in women to be cruel and destructive toward their children and that this ubiquitous fact of life is denied by all of us. I find his theory a good facsimile of the irrational assumptions that many therapists unconsciously share. I am more inclined with Lerner (1974) to understand these fears as originating in the envy of female power in the early mother-infant relationship.

Melanie Klein (1957) points to the omnipotent mother and her breast as the first object of the child's envy and her depreciation as a manner to deal defensively with this threatening negative affect. Horney (1967), who, with Klein, has been outspoken about the envy of the female's procreativity, explains the derision of women by men as originating in the loss of esteem they experience as small children when their genitals are felt to be too small and inadequate to satisfy mother. The necessity of the male to consider himself superior to women is in order to deny and prevent a past situation in which the roles were reversed and the male felt incompetent and rejected. The presence of elements of power and domination in females as well as responses of anger and rejection coming from women would be consequently feared and therefore need to be eliminated, for the first are the reminder of women's former absolute power and the latter the response to our own envious attacks upon them. What might further fuel males' fantasies of the destructive potential that can be released in the "liberation" of the female is the actual enforced suppression of women's liberty and the realistic resentment that it engenders in them.

This attempt to explain the dread of the female's potential for destruction does not imply a denial of the possibility that mothers can use their power in destructive ways. The danger of a misuse of power with children increases when the situation of females who become mothers is one of powerlessness in all other spheres. The tendency to seek satisfaction of their own frustrated needs through the children would be likely if other avenues of self-realization are denied to women (Rossi, 1964). Exercise of tyrannical and arbitrary power with children is more likely when the woman herself is under bondage and when struggles for her autonomy are labeled as abnormal for her sex.

A therapist aware of such possibilities increases the chances of a woman's freedom of expression with aggression to permit awareness and satisfaction of personal needs and thus the ability to encourage similar development in her children. Horney regrets the cultural reinforcement of a feminine prototype that is infantile and inadequate for maternal tasks because of its safety for men whose self-esteem is precarious. We have to begin

to actively disregard irrational notions of female destructiveness and male vulnerability and restore to females their freedom and enhance their potential for self-realization. In doing so, we will not only be acting in a humane and rational manner, but we will be doing much to prevent the occurrence of actual destructiveness towards children of both sexes.

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SEXISM IN THE SUPERVISORY RELATIONSHIP

Helen E. Courvoisie, M.D.
Winston Salem, North Carolina

The supervisory relationship is the primary method of transmitting psychiatric knowledge and art to the resident and analytic candidate. This relationship central to training in our profession, conducted in a dyadic or group setting, has been the subject of numerous papers and books in an effort to analyze, understand and facilitate the educational process. There is considerable debate about what constitutes effective supervision but all authors agree that the essential goal is to reduce the level of anxiety of the trainee in order that learning takes place.

Some authors feel that supervision should consist of a totally didactic experience; Eckstein (1) and others believe that the understanding of the relationship between the resident and supervisor is the main task, drawing on their observation that what the resident sees and presents of the case reflects the problems experienced in supervision. Most authors take an intermediate position that didactic material should be interspersed and an examination of the relationship as deemed appropriate and necessary. Much has been written about the problems inherent in this relationship as observed *in vivo*: topics applying to residents such as anxiety over professional identity, resistance to psychodynamic approaches, personality and empathic problems have been noted. The supervisor's difficulties have also been described e.g., as countertransfer expectations and feelings of boredom about the training process. Chessick (2) devoted a paper to the disappointment felt by both trainees and supervisors which led to failures in the supervisory process. He stated that disappointments arise when each does not communicate his needs and concerns so that they can be met or resolved. While a significant effort has been made to identify the varying factors which would inhibit the learning process, in reading the literature one becomes aware that the focus appears to be on the relationship of a male supervisor and male resident, seemingly because of the consistent use of the pronoun *he*. This observation gave rise to some questioning on my part about whether or not there has been any serious consideration of problems which could exist in a mixed-sex supervisory situation, or an all female supervisory partnership. To my knowledge only Benedeck (3) has addressed herself to the possible issues but without really exploring them. It is my feeling that there are definite difficulties here which should be attended to and resolved. This paper is based on my experiences and observations while in training and I will therefore focus on the partnership of a male supervisor and female trainee. I do not pretend that this is definitive material but rather I offer my thoughts and anecdotes in an attempt to stimulate thinking in this area. If in other life situations we acknowledge the difficulties arising from the emotions surrounding sex role changes, if we recognize the reported discomfort that many men have in dealing with the economic and philosophic implications surrounding the social acknowledgement of equal opportunity for women, if we are aware of the anxieties that women feel taking a more assertive and prominent role in society and if we recognize that sexual feelings arise naturally in situations which cannot be labeled as a traditional sexual relationship, then we may feel a need to examine the supervisory relationship of men and women and delineate the problems which interfere with an effective supervisory experience.

I came to a psychiatry program from an atmosphere which can be called a traditionally hostile one for females. Anecdotes could be recounted about that environment which a person familiar with the difficulties of upward striving female would understand. My experience in the psychiatry program was a very positive one with no overt manifestations of

bias or hostility. In fact there was much encouragement of my knowledge and talent. My training consisted almost totally of supervisory relationships which lasted from a minimum of 1 year to a maximum of 4 years. Thus, I was in intense dyadic educational processes with men, three of which lasted over 2 years. Only twice in this time was there any overt mention of sex difference. One was at the end of a year's supervision, when, on the last day, my supervisor showed me an evaluation he was handing in to the residency training committee. He told me that at the beginning of the year I had acted in a very sexualized fashion, but that I had improved in this area. There was no explanation as to what he meant by "sexualized fashion". Although he felt that such behavior interfered with my effectiveness, he waited to the last session to bring this issue up. It is noteworthy that this supervisor had been most helpful to me that year in pointing out areas of deficient knowledge and skills and aided me in remediating them. I wondered then why this observation could not have been dealt with when it was pertinent.

This man's bringing this issue to the forefront, albeit late, can be contrasted with the person who assigned me to treat a boy whose case presented serious questions of gender identity difficulties. The literature is specific that such boys must be treated by men. I felt tremendous frustration when I could not treat this child because I could not provide him with male identification model. Any attempt to address the issue was met with the answer that I could do just as good a job as a male therapist. In retrospect, I would wonder if this supervisor was denying that I am a woman, perhaps bending over backwards to treat me equally. When the parents, rightly I feel, removed this child from therapy, a conference was held to discuss what led to the treatment failure. The issue of the wrong-sexed therapist was studiously avoided.

In between the honesty and the total denial, there were different degrees of unconscious bias to be reckoned with, such as the conference chairman who diagnosed all assertive aggressive, upward striving women with no demonstrable pathology as phallic narcissistic characters. At first I was furious, particularly at any implications it might have for me, but gradually I came to understand, accept, but not like this bias. As I prepared this paper and could look retrospectively and hopefully objectively at my relationship with supervisors, it slowly dawned on me that some of the behavior exhibited by my supervisor, which seemed unexplainable at times, could in fact be related to what seems to be a taboo, and this also appeared to correlate to material related to that aspect of psychology and psychodynamics dealing with feminine sexuality. During the 4 years I was in training, I personally began to question the traditional analytic views on women. Then and now I recognize how my searching and challenging of this material could trigger many feelings in my supervisors including anxiety. I think my part in contributing to resistances and barriers can be illustrated by an incident which occurred at the beginning of my 2nd year. I was a member of a screening conference which evaluated adult outpatients. The conference was led by a talented, usually empathic, analyst. On this particular day, there were 4 other women participants besides myself. A male resident was presenting a woman patient. Apropos of the material presented, the conference chairman asked a question designed to stimulate thinking—the question being "What do women fear about the size of their vagina?". For some reason all five females looked at each other and, as one, said, "Too big—we will be less pleasurable to men". "Wrong" was the reply and the chairman went on to give a traditional explanation of women feeling their genitalia too small. Once again, the women looked at each other, but no one said a word. This incident has stuck in my mind as exemplifying 2 things: (1) How some of the psychoanalytic theories about the development of women's sexuality seemed to be questionable; and (2) how I and, it appears other women, have dealt with these questions by silence. Although I

became more verbal later about my discomfort with these theories, a true dialogue never seemed to develop about these issues, partly because of my anxiety, and, I think, partly because of what feelings these supervisors were experiencing.

This silence and frustration can be seen once again, to interfere with the honesty and openness which seems desirable in a supervisory relationship. When a supervisor very enthusiastically and warmly congratulated me on my growth as a therapist, he told me how pleased he was that I had finally worked through my resistances and could accept and believe in the concept of penis envy in the normal development of women. This was one of the saddest days of my life as I valued my experience with him, and I realized that I had been deceitful with him and had marred an open, trusting working and personal relationship. I had kept silent about my change in thinking, and, on the surface, appeared to be treating this patient with this concept in mind.

The last area that I would like to address myself to is perhaps the most difficult. I am aware that I brought to the supervisory experience all of my feelings about men, resolved and unresolved. These included feelings of sexual attraction and the accompanying emotions. I have been very attuned to these feelings in other kinds of relationships including those with men with whom I am professionally associated. Benedeck (3) attributes this awareness to the fact that because there are so few professional women in relation to men that the women are confronted with these feelings constantly. It has been my experience, particularly in working with a male co-therapist, that these feelings have to be faced, talked about and settled. Many times, enough to be significant, my co-therapists and I have found that at least a minimal confrontation of this issue resulted in an increased therapeutic movement in the groups or families we were treating. Our relationship relaxed and became more intimate in areas other than the sexual. Never once was this issue breathed about in a supervisory relationship. I do know that this existed in several of my relationships in a highly disguised fashion. Sometimes this would surface in a manner both annoying and amusing.

With one supervisor I seemed to have a relaxed, friendly arrangement. When the patient, a little boy, became anxious in therapy and aggressively started looking up my skirt and seemingly could not be contained, my supervisor changed personalities. He became aggressive, and insistent, stating over and over that I had misjudged the case and was not dealing with pregenital issues. He denied the sexual aspect and whatever that meant to us. I solved the problem by wearing slacks which calmed both my patient and my supervisor.

The implication of the thoughts and anecdotes I am recounting is that, in the midst of meaningful experiences both professional and personal, there were islands of subtle craziness, the kind of craziness which is brought about by unspoken thoughts, and elusive nonverbal communication - similar to that which we see in our patients. I feel strongly that the lack of communication and sharing of thoughts and feelings between the supervisor and supervisee contributes to this state of confusion and frustration.

If we encourage open and honest expression in our patients, then should we not do the same! Both men and women need to examine and explore these issues for their mutual benefit and comfort. It would appear that the area of sexual feelings in the supervisory relationship has been taboo in the literature and, if this is true, we need to deal with this taboo as we have dealt with others.

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RESIDENCY TRAINING OF WOMEN IN PSYCHIATRY— LITERATURE REVIEW AND REFLECTIONS

Lesley Kriegman Braasch, M.D.
Durham, North Carolina

The first American trained women physician, Elizabeth Blackwell, entered medical school in 1847. During the 19th century few women entered medical training and most of them were trained in women's medical colleges and were not accepted in the mainstream of medicine. From about 1905 to the 1940's approximately 4% of graduating medical school classes were women.(1) The percentage of women physicians in the United States has been between 6 and 7 percent for the past 35 years.(2) This percentage does not yet reflect the marked increase in the number of women accepted as freshmen medical students in the U.S. Since 1964 the percentage has doubled from 8.4 to 19.7% of the entering class.(3) In contrast between 60 and 70 percent of the physicians in the Soviet Union are women, although under a much different social and educational structure than in this country.(4) The only western culture with fewer women physicians than the U.S. is Spain. Germany has 20% women physicians, the United Kingdom 16% and France 13%.

In discussing the role of women in medicine most studies have focused on statistics which describe women's contributions or lack of them as compared with men and thus justify conclusions that it is or is not feasible to train women to be physicians. The most recent of these figures show the following: Of the women physicians responding to a questionnaire, 45% reported full time medical activity since completion of training in contrast with 95% of the men and between 84 and 91% of the women reported being professionally active.(6, 7) in the year 1964, 54.5% of women responding reported full time professional activity, over 2,000 hours per year, and 30.5% stated that they work part time. This averages out to women contributing approximately 1900 hours as compared to the average for men, 2800 hours per year. Accordingly, on the average men physicians see 1/3 more patients and work 30% more hours per year in a given year than the female physicians.(8) These conclusions failed to consider several points.

1. Women physicians are more frequently in salaried positions which traditionally have shorter working hours than private practice.
2. A large percentage of the women physicians are in fields which involve little or no patient contacts, such as pathology and radiology.
3. Results are compiled for only a 1 year period rather than over an entire career. Longevity studies carried out by Dr. Goodman based on 19,000 death certificates of physicians from 1969-1974 confirmed that women physicians follow the pattern of the general population and live longer than men.(9) Therefore, it is possible that yearly differences between male and female physicians may not be significant over a life time. Up to the present this information has not been analyzed.

Attempts have been made to discern what population of women become physicians. Most of this work has been done statistically rather than dynamically. The women physician is more likely to have been raised in a family where the father is a professional person, frequently a physician. She is more likely to have a mother who has been educated beyond secondary school and approximately 50% of the mothers have been employed outside the home. She is also more likely than the non-physician women to be the eldest or only child. She has usually decided on a career in medicine by early adolescence and has always had a high interest in biological sciences and desire for individualization.(3) This last point psychodynamically is a very interesting one and may account for the difficulties in women physicians have with working and talking together about their com-

mon problem. They desire to individuate and be unique-different than other women and in a field where there are a few others like them. Thus the saying "women are their worst enemies" may in fact be true. The image of uniqueness is another area that needs further examination particularly in light of the increasing number of women entering the field.

Another statistical generalization is that single or divorced women physicians, work longer hours with less lost time than married women, particularly if they have three or more children.(10) That is, they work more like men or conform more to the work standards established by male physicians. This includes an average of 50 to 60 work hours per week. Obviously there is nothing inherently wrong with this life style but it raises the following question "what role does work play for these physician-men and women?" and "what other life roles have they selectively omitted?" One can be married and have children and still selectively not participate in a social role or interpersonal relationship.

More women physicians have entered careers in psychiatry(11) than any other specialty other than pediatrics in the years following 1925. The American Psychiatric Association Task Force on Women which was created in 1972 has collected most of the data about women psychiatrists. That committee had as its purpose:

1. To define and recommend action to meet the mental health needs of women . . .
2. To promote women psychiatrists' involvement in academic research, administrative and professional organizations . . .
3. To review and stimulate research and development in theories necessary to implement the first two purposes.
4. To provide support systems for women colleagues."

A 1970 census of psychiatrists in the U.S. found that out of 26,000, 12.5% were women. Ninety percent of men and women psychiatrists reported 3 or 4 complete years of training. Thirty-four percent of the women and 50% of the men were board certified. Twenty-two percent of the women and 10% of the men were practicing child and/or adolescent psychiatry. Ten percent more women than men are working part time, retired, or not working. Approximately 81% of the men and 73% of the women were working. There were a greater proportion of women than men employed by state mental hospitals and educational institutions other than medical schools. They were employed in salaried positions more often than men. Women average 39 hours unduplicated work per week and the men 49.(12)

Few of the women psychiatrists are in academic or research settings.(13) Although many women are interested in teaching and in administrative careers their acceptability is limited by the demands to publish and do research. That is, to wear the hats of teacher, therapist, administrator and researcher in addition to mother and wife is nearly impossible. Why is this important?

1. A recent survey noted that 94 university psychiatry staff positions in this country were unfilled.
2. It is important for women psychiatrists to have women role models. This can be accomplished by contact with psychiatrists as supervisors and teachers.
3. It is important for the training for all psychiatrists to understand the psychology of women whether the women be their patients, supervisors or peers.

Why are so few women in academic psychiatry? Women must walk a very difficult tightrope in order to succeed in the competitive arena. They must be aggressive and assertive, but not in a manner that is castrating. They must be competent but their competence in itself quickly leads to envy and discomfort on the part of their male colleagues.

In a level of sophistication where individuals should be evaluated and accepted on their own merit, the biased feelings about women may result in conscious or unconscious exclusion of them. Dr. Karl Menninger expressed the following in an address to the American Medical Women's Association in 1936. "The social and intellectual inferiority under which women labor in our society whether justly or unjustly tends to sharpen their eyes and ears to the needs of those for whom other circumstances and sexual difference have caused suffering... I must add that my observation has been that most women physicians failed to exploit this advantage but strive rather to imitate men. To imitate their male colleagues and follow them even in their errors discarding the opportunities and functional endowment's nature has given them... such women do not recognize how their envy is leading them to repudiate their birthright. They cannot realize that unconsciously men envy them less than they envy men." (14) It may be exactly this same "birthright," uniqueness, or femininity that is not acceptable or is too threatening to a woman's colleague.

Sigmund Freud, in the New Introductory Lectures wrote (15) "psychoanalysis does not try to describe what a woman is - that would be a task it could scarcely perform - but sets about inquiring how she comes into being... In recent times we have begun to learn a little about this thanks to the circumstances that several of our excellent women colleagues in analysis have begun to work at the question." As most of the research and theories of the psychology of men have been worked through by men so the psychology of women has been worked through by women namely Helena Deutsch, Karen Horney, and Clara Thompson. What this suggests is that there is a need for trained women in psychiatry at clinical and research levels.

Residency programs in psychiatry were among the first in this country to offer part-time or flexible training programs for women. These flexible programs were based on several factors:

1. A proportionally large number of women are trained in psychiatry.
2. Women need not postpone having children in order to complete training.
3. Women may need training programs that are different than those designed for men.

As of 1970, 289 hospitals reported they were willing to offer part-time programs for women in some specialties and there were 94 women residents in part-time programs, 50 of whom were in psychiatry.

One of the first residencies designed for women was at New York Medical College in New York City. (16) The program was started in 1962. Women residents trained for 4 rather than 3 years, the emphasis was on the physician mother and the program was arranged to fit the academic year. The women had less frequent night call but enough to assure the necessary training experience. The program was visible and various forums were established to discuss and work through the staff's reaction. A report on the program in 1972 after 10 years, Dr. Kaplan writes "(the program was developed) largely from the conviction that the conflict between the role of wife, mother and resident is not irreconcilable. It was hoped by demonstrating the feasibility of being both mother and physician simultaneously that a more optimal use could be made of medical womenpower. Also a long range objective was that recruitment of women into medicine would be increased by making it more acceptable and attractive vocational pursuit for the younger women seeking a profession who plan to be both mother and a professional." (17) Sixty four women were enrolled in the program over those 10 years. There were no drop outs and every woman who took the Neuropsychiatric Boards passed them on her first attempt. A number of these women were retained in staff positions at various teaching hospitals.

Another program in psychiatry is the part-time program at Sheppard Enoch-Pratt, which is 2/3 time for a 4 year period with no particular arrangement for longer breaks or vacations.

Duke Psychiatry Department has since 1968 made available a part-time or individualized training program for women. Dr. Ewald Busse stated the following: "Recognizing the combining of motherhood and medical training as a special problem of women physicians, the Department of Psychiatry has instituted a part-time residency program for such individuals. Women physicians are too valuable a resource to be detoured from training by the full-time requirements, thus the part time program was instituted in the interest of the mental health of women physicians and their children and to meet the needs of medicine. This special program is flexible as it is designed to meet the unique needs of the individual."

I completed my first year of residency full time at a teaching hospital in Texas and was one of two women residents - the other woman was in child psychiatry. I was very isolated for a number of reasons, none of which improved when I became pregnant after three months. I took time off from training and when our son was a year old entered second year training at Duke. The flexible program was helpful to me. I started at 2/3 time and after one year went 3/4 time and for the last nine months full time, thus finishing the last two years of my training in 2 1/4 years. The increase in my work hours paralleled our settling down including finding a reliable housekeeper, my husband's schedule changes and our son's needing less individual time with me. My husband and I can each work up to 45 hours per week without much stress. Much of the credit for this not being a stress goes to my husband who shares in household and family responsibilities.

The course of training has not at all been glowing appreciation. I have a number of regrets and resentments too. Some have to do with my own internal conflicts and other are interpersonal. For a long time I tried to do as much as everyone else but in less time - that is, to show I was as good as the rest. As a matter of fact, I frequently tried to show I was better than the others. This common phenomena is described very well in a paper by Dr. E. Shapiro(18) and is identified as a reason why many women residents are reluctant to request flexible training programs. At times I have resented my limitation, that I had to postpone work or activity that interested me. I found that the particulars of a part-time program had not been worked out and few people were willing to understand my needs as a mother and wife and help me work out a training program. The scheduling of required conferences was such that I had difficulty sticking to a 30 hour work week unless I came in to work twice in one day. Associates did not know I was part-time until I told them and few residents or staff were aware of the reasons or needs for a part-time program. The forum for discussions described by Kaplan were not present. There have been no seminars on the psychology of women and only one faculty woman was available for role modeling. Only rarely did the women in the program share their problems and observations.

I coped with and resolved the problems in several ways, including being in psychoanalysis and writing this paper. Very rapidly and with some hardship, I learned as much about others' schedules and how the program functioned, thus becoming my own counsellor.

Many examples could be given of non-support and actual antagonism toward women in special or part-time programs.

Several authors have dealt anecdotally as I have with how individual women accomplished their training and practice.(19, 20, 21, 22) Other papers note the need for day care centers for women in psychiatry. To note parenthetically there have been times in my training when the housekeeper has cost 2/3 of my salary. An additional advantage of

these centers could be to serve as training and observation centers.

In conclusion, the training of women in psychiatry is essential and important to the profession and our understanding of women as well as to the growth of an individual woman, the physician. The training can be adapted to meet the needs of women who choose multiple life roles. For the woman it is important that she be aware of her limitations in time although not over a life time, have an understanding and supportive husband, if married, and that she is able to arrange for good-enough mothering and care for her children when she is away from home. In staff relationships it is important that the woman's unique and special needs be considered. The woman is not herself special but does have different demands on her.

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PSYCHOLOGICAL ASPECTS OF ABORTION*

Maria Gispert, M.D.
Department of Psychiatry
Division of Child Psychiatry
UNC School of Medicine
Chapel Hill, North Carolina

Psychological Aspects of Abortion

Pregnancy is a natural event, with positive emotional connotations and growth-promoting values for most women(1), and the decision to terminate a pregnancy cannot be made without a certain amount of conflict, even if a child is positively unwanted. The ambivalence and the emotional distress involved in the decision to obtain an abortion and to actually carry it through stem from a multitude of factors which vary from woman to woman.

An abortion is not an isolated event in a woman's life. The feelings surrounding an abortion cannot easily be differentiated from the complex array of emotions the woman may have at that time. These include her feelings about herself as a female and about her ability to have children, her feelings about her own sexuality, as well as her emotional relationship with the male responsible for the conception and his attitude toward her pregnancy and choice of abortion. She does not exist in a vacuum. Her family's feelings, real or imagined (irrespective of their knowledge of the pregnancy), can subtly influence both her decision-making process and her degree of satisfaction with her final choice. The effects of her own and her family's religious beliefs, the norms of the culture in which she lives, and in particular its degree of acceptance of abortion, will also have their impact on the woman's adjustment to her situation. All of these forces may act in different directions, some favoring the continuation of an unwanted pregnancy and other contributing to the desire to terminate it. The strength of the forces supporting termination will also determine in part the woman's satisfaction with her choice of abortion.

As with any other stress, the magnitude of the problem of an unwanted pregnancy depends both on the woman's capacity to deal with it according to her physical and emotional health, and also, very importantly, on the alternatives or external resources available to her. By looking at how the cultural, personal and interpersonal factors may vary, and at how the actual abortion procedure is handled, it is possible to surmise what degree of satisfaction, relief and even growth a woman can experience, or what possible adverse reactions may occur.

We will be discussing these issues for women who have made a free decision to terminate an unwanted pregnancy for psychosocial or economic reasons rather than medical or eugenic ones. In the latter instances, many other considerations are involved which would obscure the more universal issues involved in a voluntary disruption of pregnancy. We will also discuss the effects of counseling, both before and after the abortion experience. A survey of relevant articles involving follow-up studies will show the trends in abortion research and in the psychological findings and how they have changed with gradual liberalization of laws on abortion. Finally, we will discuss some possible trends that seem to be emerging in society and in abortion patients as the consequence of liberalized abortion laws and resulting attitudinal changes.

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1. Cultural Influences on Women Seeking Abortion

A. Illegality and Its Consequences

When a society condemns abortion as a "crime," persons involved in an abortion, either as recipients or practitioners, can be expected to have negative feelings about their participation.(2) Since the laws of a country usually can be assumed to reflect the opinion of a majority of its citizens, those who break these laws may fear not only legal action but also possible condemnation by their peers and their community. To take action at odds with the values of one's society places the individual in a vulnerable and exposed position, which highly increases the potential for emotional distress.

Physical danger is almost always present when abortion must be performed illegally. Although sympathetic well-trained professionals may be available (usually accessible only to the wealthy), in most cases illegal abortions are performed by a variety of amateurs with dangerous methods and very rudimentary or non-existent sterile techniques. Because of the necessity for secrecy and the desperation of their situation, women in these circumstances cannot evaluate or choose the kind of service they will receive. Complications cannot be treated and high morbidity and mortality rates occur. Thus the trauma of having to decide to terminate the pregnancy is compounded by the all-too-reasonable fears of physical danger, possible criminal charges and community disapproval.

As laws range from total prohibition of abortion to complete freedom of choice in the matter, so can the extent of possible psychological anguish range from great anxiety and fear to a calm knowledge that the woman can make her choice without threat of reprisal or damage to her health. In countries with almost total freedom of choice, as the U.S. now has, a woman can sometimes find group support and encouragement comparable to an "esprit de corps" in the form of pre-abortion group counseling(3,4) where she can openly discuss her feelings and her reasons for termination with other women in similar situations.

Where abortion is prohibited, the majority of the medical profession generally conforms to the national policy and is against abortion. The health professional, because he or she is vested with authority and knowledge, is a very important person to the patient. The person who confirms the diagnosis of pregnancy may at that time exert a very powerful influence on how the woman is going to feel, what decision she is going to make, and how she will carry it out. This often depends on their attitude of support or rejection. The medical profession has been trained for years to preserve life, but it also has been trained to alleviate suffering. Physicians especially are confronted with very difficult decisions when the law forbids a course of action which they feel would benefit the patient. When a desperate woman wishes to interrupt a pregnancy, the physician may break the law by performing the abortion, refer her to an "abortionist" if he or she doesn't want to take direct responsibility, or, if totally opposed to abortion, may try to dissuade the woman completely.

In countries with intermediary degrees of permissiveness, abortion is granted under special conditions, usually subject to approval by a group of members of the medical and allied health professions (generally a hospital board or committee). The applicant usually is interviewed by several persons, must state quite strongly her reasons for not wanting a child, and then has to depend on others for their decision while losing control over her reproductive life. Rossi(5) compares this supplication to the degrading "need test" in the welfare area, with its lack of dignity and disregard for human rights.

Legality does not result in instantaneous acceptance, however. A change in any law is

usually effected by a small group within a society, and general attitudes lag behind practices.(6,7,8,9) Since liberalization, abortion in the U.S. has slowly become available to the public as medical personnel have become more willing to perform the necessary procedures and have grown more understanding and sympathetic towards patients requesting this service, and as more women become accepting of abortion as an alternative to an unwanted pregnancy.

With increased availability and improved techniques, there is less emotional and financial stress for the woman going through the steps necessary to procure an abortion. It is anticipated that this decrease in external stress will be accompanied by a similar decrease in negative feelings following an abortion.

B. The Influence of Cultural Attitudes Toward Family Size

A society's attitude toward abortion, and thus toward those seeking abortion, is certainly affected by its notion of optimum family size.

Certain cultures traditionally favor high fertility rates for numerous reasons. Where infant mortality is high, families need to bear a greater number of children in order to insure a certain number of survivors. Where families depend on "child labor" for farming or running the family business, children help with the economic survival of the family. Where sons and daughters are relied upon to take care of the parents in their old age, children are a sort of "social security," and bearing more children ensures this. Where the society's religious beliefs disfavor sexual intercourse without the purpose of procreation and proscribe the use of contraceptives, abortion is often viewed as "killing" the unborn child. And, where bearings or raising large numbers of children is an important way of gaining or enhancing one's status, the large family is a source of pride. Consequently, any desire to terminate a pregnancy is viewed as abnormal at best, and with contempt or hatred at worst.

Some of these conditions which in the past justified the desire to bear many children have changed or completely disappeared. Infant mortality has diminished almost everywhere. With the mechanization of agriculture and greater urbanization in developed countries, there is little need for child labor.(10) The large family has become not only unnecessary but in fact a burden: with more children surviving, housing becomes overcrowded; as medical and dental care become available, these usually have to be paid for on a per capita basis; the increase in both educational opportunities and requirements keeps children in school for longer periods, pulling them away from fields and family businesses and postponing their potential economic value to their parents. As women are offered more opportunities to achieve social status outside motherhood, they tend to accept more diversified roles, such as working outside the home, which tend to conflict with childrearing.

In Western Europe, therefore, the social revolution that accompanied the industrial revolution has operated to make children less rewarding and more costly than they have been in the past. Urbanization and modernization have increased the costs of childrearing, e.g. as regards housing, food, education, standards of living, social and geographical mobility, and the consumption of "culture." At the same time, the possible contribution of children to the household economy have decreased. The anti-natalist effect of a modern system of economic development has been well documented for England.(11) Political influences can effect the same results, as in Eastern Europe and the U.S.S.R.

Societal norms and ethics change slowly, however. In the U.S. during the past decade family size has become a common subject of public debate, due largely to concern regarding environmental health and the depletion of natural resources. The "population

problem" and the need for "zero population growth" (ZPG—the desirability of the two-child family as a means of achieving a stationary population) have become recognized and are growing in acceptance.(12, 13)

As the need for limiting family size becomes better understood in other countries, it can be expected that acceptance of abortion as one means to this end will also increase. This should remove one source of external pressure and confusion from the woman deciding to abort.

C. Religious Attitudes Toward Abortion

Where the dominant religions in a society do not tolerate or are strongly opposed to abortion, as is found in Catholicism, Judaism and Islam, it can be assumed that the laws and attitudes of the people will tend to reflect these ideologies. A survey of countries where abortion is "illegal without exception"(14) reveals that most of them, principally in Latin America, are under strong religious influences, primarily Catholicism. Those permitting abortion only to save the mother's life include mainly African or Islamic nations. The Jewish state of Israel permitted abortions (as of 1973) usually for medical reasons only. Women in the more restrictive areas will be subject to greater degrees of conflict when abortion is considered a moral question and not just a medical procedure.

II. Personal and Interpersonal Reasons Favoring Continuing Unwanted Pregnancy

In addition to the external, personally uncontrollable influences on the woman faced with the difficult decision between abortion or bearing an unwanted child, there are also more internalized conflicts, both as an individual individual and as a part of a network of interpersonal relationships with others who have an interest in her pregnancy (husband/boyfriend, parents, siblings, friends...) Many reasons, biological, psychological and social, exist which favor the woman's continuing with even an unwanted pregnancy. How strongly these are felt by the individual woman will affect her psychological make-up both before and after an abortion.

Before consideration of these factors, a comment should be made about the nature of "unwanted pregnancies." A common assumption found in the psychiatric literature tends to blur an important distinction. The assumption is that unwanted pregnancies are really symptoms of the "unconscious desire for a child," and that they have resulted from "willful exposure to unwanted pregnancy."(15,16) But as Friederich(17) wisely points out, in sorting out the motives for having sexual relations, there are great differences between: 1) wanting to have intercourse, 2) wanting to become pregnant (consciously or unconsciously), and 3), wanting to have a child. Motivations for each can differ greatly. Unwanted pregnancies which actually result in abortion can generally be assumed to be the result of wanting to have intercourse and/or wanting to become pregnant, and only in rarer cases as a reversal of the actual desire to have a child. Failure to draw such distinctions has contributed to the unsupported assumptions outlined above. (That sexual intercourse per se is pleasurable for women has often been denied or ignored, as has the entire subject of women's sexuality outside of procreativity until recent years.)

In societies where birth control information is readily available, there is always the question of why it was not used if a pregnancy was truly not wanted. But sexual functioning in any culture is so much under emotional, moral and religious influences and legal constraints that it is often difficult for the individual to separate all these components and behave rationally. The reasons why the unwanted pregnancy occurred will certainly be relevant to the feeling which the woman will have after she has terminated it.

A. Personal Factors Favoring Continuation of Unwanted Pregnancies

The feelings a woman has about her own body have a significant impact on her at the time of an unwanted pregnancy. These emotions have developed over a long period of time, and involve her image of her own sexuality and of her procreative ability.

From childhood, the growing girl has developed concepts and emotions about herself as a potential mother. Having children is generally cherished as a natural and fulfilling experience. From the doll-playing stage, girls rehearse the mothering role, copying and assimilating from their own mothers and from other women the ways to talk to, handle and deal with infants. As a boy becomes aware of his penis as a sexual object, a girl, in a less direct and less obvious way, does become conscious of the precious capacity to have babies.

In adolescence, the girl's body changes and the appearance of secondary sexual characteristics make her blossoming into a sexual being quite evident. The development of the breasts, the rounding out of the hips and the appearance of the menarche all point towards the reproductive capacity of the emerging woman.

Along with these bodily changes, her self-concept of "I am a woman" further develops, with all the facets of sexual identity. The wish for sexual experimentation, the evaluation of her own attractiveness in reference to males, the further development of her self-image and self-esteem in the sexual area, bound up as it is with the reproductive function, all may contribute directly or indirectly to the desire to become pregnant.

Almost every woman wonders about her fertility to some degree and may wish to prove its capability. She may be more or less aware of that wish, and how she deals with it is going to depend on how she feels about herself, about the significant others in her life, and on how her society rewards or inhibits exercising that desire. The latter, as mentioned earlier, is an external factor influencing the woman, but it has also been internalized during the socialization process. Having become pregnant, she may realize that she does not want a child and she finds herself in conflict with what others in her culture may romanticize as the most fulfilling task in a woman's life—the ideal of motherhood. Most societies have prepared a woman to feel "unnatural" for harboring any desire not to have a child, and this creates a feeling of guilt or of being "abnormal." The psychoanalytic literature unfortunately has reinforced this attitude by describing a woman's psychic development as incomplete until she has borne a child. The feeling of being different from others adds to the internal conflict, and may lead her to bear the child she does not want, or at least to be more indecisive about the pregnancy.

The stage of life a woman has reached also has a profound influence on her attitude toward pregnancy and on the reasons why she has become pregnant with an unwanted child.

In adolescence, a pregnancy can be associated, as we have seen, with the wish to be considered as a "grown up" or as a mature woman. Late in the reproductive life cycle, a pregnancy can be used to deny the approach of menopause with its real or imagined decline in the woman's sexual attractiveness. At either age, the decision to terminate can cause conflicts because, although a *child* is not wanted, the pregnancy itself was not a totally "unwanted" occurrence. Women at all ages can also desire pregnancy to overcome a sense of inferiority or inadequacy, especially uncertainty about their own femininity. Again we should emphasize, however, that the unwanted pregnancy often is the accidental by-product of a woman's fulfilling her desire for sexual relations, rather than the result of "unconscious" desires to have a child.

B. Interpersonal Factors Creating Conflict about Pregnancy

The relationships with those most involved with a woman—her family, her male partner or both—and how these are affected by the pregnancy will contribute to her feelings and decision making. It is difficult to discriminate which interpersonal motives for continuation or interruption of pregnancy the woman may be aware of, and which are acting on her in a more subtle way.

The pregnancy may initially have been desired for several reasons relating to the male partner. The woman may have wished to share in producing a new life and may have idealized a child that would belong to both of them. She may have wanted to test the male partner's willingness to continue in a relationship, or his feelings about marriage to her. She may have hoped to make the union more permanent, to further interest and involve the man so that he would assume more emotional and financial responsibility. The pregnancy may have been sought to please the man, either as a gift or under his pressure, especially in subcultures where paternity enhances a male's masculinity both to himself and to the group.

If the relationship does not continue or develop as was hoped, the pregnancy can then become a burden, and conflict arises when what was welcomed and thought to be a solution to problems becomes an added source of regret. When the relationship has totally disintegrated, or in the absence of any relationship at all with the putative father, a woman may at first continue to want to have the baby in order to have someone to love her or just to have something to call her own; these needs are most frequently found in women from economically or emotionally deprived backgrounds. When the woman realizes the difficulty in continuing the pregnancy and bearing the child, psychological stress can be anticipated, the degree depending on how much the woman had emotionally invested in the fetus.

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Another important set of interpersonal relationships affecting an unwanted pregnancy and creating indecision for the woman are those she has with her parents and other members of her own family. These are particularly potent influences when the woman is strongly tied to her family, either in adolescence or in later years if she has remained emotionally or financially dependent on her parents.

Several pathological relationships within the family seem to correlate strongly with unwanted pregnancy. Over-identification with mother and the mothering role can enhance the chances of conceiving at a premature age. A young girl may try to attract the parents' love and to test if they really care about her by placing herself in a compromising situation. Some young women may be in competition with sisters for the love of the parents, especially when the sisters have children of their own. A young woman who perceives herself as being of central importance to her mother's life may feel the need to give her a child, in order to enable herself to leave the family. The subtle pressure of a seductive father may also stimulate the desire for a pregnancy even though, because of incest taboos, he does not produce it. Rebellion against parents can contribute to the sexual acting-out which produces the undesired conception, as when an adolescent becomes pregnant while proving that she can do just the opposite of what her parents have advised her to do. For another, the sexual activity may be proof to herself that she can make a decision of her own, independently of her parents, and pregnancy is an unfortunate consequence of her decision. For others, pregnancy is seen as the only way acceptance of a marriage the parents do not approve of can be gained; this is particularly forceful when social position is at stake.

When a woman becomes more objective about the realities involved in having the child, she may become aware of a wish to discontinue the pregnancy. If family members or the man involved disapprove of abortion, she is caught in a dilemma. Thus, her final choice and the outcome of that choice are subject to additional pressures favoring continuation of an unwanted pregnancy. (This apparently is particularly common in the Black culture in the United States.)

Of course, in the opposite situation, when the woman wants to carry the pregnancy to term but the meaningful people in her environment—her husband or boyfriend, or parents, especially in cases of adolescent girls—are against her wishes and exert pressure for her to have an abortion, the stress is comparable. If she gives in, the woman often has many negative feelings toward the people who coerced her into having the abortion, regrets the loss of the pregnancy, may have guilt and depression, and sometimes becomes pregnant again to replace the lost pregnancy.

III. Reasons Favoring Interruption of Unwanted Pregnancy

For a pregnancy to be successfully terminated by abortion with the fewest possible aftereffects, a woman must believe that her decision was justified. Different rationales carry varying weights for each individual, but the more convinced a woman is that the potential child was truly not wanted and burdensome, the less she is likely to regret its loss.

Like the reasons for wanting a pregnancy, those related to not wanting a pregnancy to continue also can be divided into a variety of personal and interpersonal variables. In our above discussion, some of these have been mentioned. Usually, several considerations are involved that cannot be isolated from each other.

A. Personal Factors Favoring Termination

Among reasons for requesting an abortion, age, marital status and financial problems stand out as the most frequent considerations. These tend to overlap with considerations of educational and life goals, as well as with each other. In addition, women sometimes cite consideration for the unborn child and for the quality of life of other family members and also their having attained the desired family size as contributing heavily to their choosing abortion. We will take up some of these factors below.

1. Age and Related Considerations

Statistics on abortion candidates' ages show that adolescents and women in their early twenties are the most frequent applicants in the U.S.(18)

A young adolescent girl may feel that her body is not completely developed enough to bear a child. She may recognize that she is emotionally too immature for the responsibilities of child rearing. Usually the adolescent is still in the process of acquiring an education (of greater importance in industrialized countries and of growing importance in emerging nations), and is generally dependent on her parents for most of her needs. At younger ages, the relationship with the male partner is more often tenuous or non-existent; he is most frequently an adolescent himself and also in school and financially dependent, so marriage and/or a child are not good solutions; in some cases, it is the partner who helps the girl to understand the hardships of having the child. Most societies and parents condemn an "out-of-wedlock" birth, and the emotional trauma of going through with a pregnancy only to give up the baby for adoption appears overwhelming to many young women, so abortion appears as the best option available to them. It also seems easier to surrender a fetus than a full-term baby. Many women express worry

about the child's whereabouts and the care it would receive if they bore it and gave it up for adoption.

A young adult may not want a baby for many of the same reasons as the adolescent. She may simply, as a matter of choice, not want a child. The relationship with the male partner may have changed since the conception or may be discontinued due to loss of interest, separation, divorce or death. A recent marriage may be on shaky ground due to numerous stresses which would potentially be aggravated by the birth of a child. The unwanted pregnancy may follow too closely upon the birth of a planned child, and the young mother may wish to avoid overloading her "mothering capacity." She may already have reached the emotionally unstable state described as "mothering insufficiency" (19) due to other stresses. Further, more women are seeking higher education and following non-traditional occupations and professions, and an unplanned pregnancy may threaten interruption or loss of these goals. Some women find certain activities or sports stimulating and rewarding and do not want to have to abandon them while carrying a pregnancy to term.

Abortions are sought by mature or middle aged women for most of the same reasons noted, as well as some which are unique. While cancer goals may still enter into the decision, more frequently the feeling of advancing age or the sense that one already has fulfilled one's mothering needs make the late pregnancy undesirable. Moreover, for quite good reasons, fear of producing a deformed or abnormal child also increases as the upper limit of the childbearing years is reached.

2. Marital Status

In most societies, as described elsewhere in this volume, pregnancies which occur outside the well-delineated limits of social acceptability can result in various forms of disapproval, ranging from ostracism or insult to the death of the transgressor. Even in societies with milder proscriptions against illicit pregnancy, there still exists a certain loss of status to the unwed mother and her family. Abortion can be an alternative to such fates. The structure of the nuclear family, with both a father and a mother present, is almost universally believed to be helpful in best fulfilling the needs of children. When this is absent, societal pressures and the woman's own shame at violating her society's dictates may combine to strengthen her wish to discontinue such a pregnancy. The stronger the form of disapproval, the more appealing will be this solution.

3. Desired Family Size

One reason for desiring termination of pregnancy given by women of a variety of ages and marital situations is the condition of having already borne the desired number of children. Once again, the reasons why the unwanted conception occurred may vary, but the fact that a woman already has the number of children she wants or feels she can care for can be a compelling reason for deciding on abortion. This number may be none; recently, in the U.S. at least, the alternative of having no child has been chosen by growing numbers of women, and hopefully the social prejudice against "barren" women will diminish.

A subsidiary but important correlate of having attained the desired family size is the effect of having a large number of children on the living standard of the whole family. More children decrease living space and deplete resources for education, food and general support. Many women wish to help to improve the quality of their own and their families' lives, and an additional unwanted child often represents the margin which prevents them from accomplishing this. Women in developing countries and women

whose families are struggling to narrowly escape the poverty or subsistence level are likely to be in the group expressing this as their prime reason for choosing abortion.

4. Consideration for the Unborn Child

Many women who realize that their age, state of life or financial situation make a pregnancy unfortunate also see their desire to prevent the birth as being in the best interest of the unborn child. They perceive that a child born to someone in their particular set of circumstances will be greatly handicapped throughout life. Their insight into this problem is more than just speculative. Studies have shown that children born as products of unwanted pregnancies fare much worse in all areas of adjustment. Throughout the ages, unwanted children have been murdered, abandoned, sold, exploited or mistreated. Infanticide was a regular practice in antiquity in both the East and the West, for legitimate and illegitimate offspring alike. It declined in the West in the Middle Ages except for illegitimate children, who frequently were killed as late as the nineteenth century.(20) Unfortunately, it still occurs today.(21,22) Foundling hospitals and orphanages were opened to take care of the large number of abandoned children who were the products of unwanted pregnancies. Child abuse has been widespread, but not until the nineteen-sixties has this been thoroughly exposed and studied.(23, 24)

Without approaching the extreme of physical violence, unwantedness can result in a pervasive and deleterious psychic destructiveness. This is difficult to quantify, but it results in impairment of the child's physical development (failure to thrive) and/or emotional development. There are few well-documented studies of the effects of unwantedness, but a much-cited Swedish report by Forsman and Thuwe(25) followed the life outcomes of 120 children born to mothers who were denied an abortion, as compared with a control group. The unwanted children attained lower educational and socioeconomic levels, with a higher incidence of alcoholism, clashes with the law and other social problems.

In general, children born to mothers in their early teens, children poorly spaced (for instance, born to a woman who has had three or four children in a five-year span of time), children from large families—particularly the younger and therefore less-wanted ones—are all at much higher risk for having emotional problems and to eventually require psychiatric hospitalization.(26,27) Preventing the birth of unwanted children seems to be the single most effective measure of preventive psychiatry.(28, 29)

B. Interpersonal Factors Contributing to the Abortion Decision

Many factors involved in the decision about a pregnancy have both personal and interpersonal aspects. For example, a woman's relationship with her family, boyfriend or husband will certainly be influenced by her age and marital status.

As mentioned earlier, marital status is often an important factor in the decision-making process. Also of great significance is the quality of the relationship with the marital partner or potential marital partner. If this is poor or in danger of collapse, abortion may be more easily decided upon. Within a stable relationship, a couple may jointly decide on abortion if they do not desire to have any children, or at least not at that time. The moral support of the male partner, whatever the nature of the relationship, will make that resolution easier for the woman and therefore decrease her stress.

The single adolescent or any single woman living at her family's home will be especially affected by parental and sibling approval or disapproval. Where parents and siblings see the logic of her choice of abortion and confirm her in her decision, it will be easier to proceed. When the abortion is sought in order to conceal the pregnancy from the family,

the compelling reason is to avoid strife but the personal stress on the patient due to this lack of support may be greater.

If the pregnancy resulted from rape or incest, the decision to have an abortion may seem clearer, but the whole traumatic chain of events may leave a residue of problems which are difficult to differentiate from the abortion itself. Familial support is important in these cases to help relieve the inherent unpleasantness of the situation.

IV. Emotional Impact of Various Abortion Procedures

The type of abortion procedure a woman undergoes may also affect the feelings she has afterwards. There is overlap between the effects of the medical techniques themselves, which range from being brief and atraumatic to being a somewhat involved procedure requiring hospitalization, and the feelings the woman has surrounding the decision and its outcome. Which procedure a woman undergoes has in turn been determined by the duration of the pregnancy, which itself has been influenced by her degree of indecision about her pregnant state. The real cause of the feelings after the abortion, like the confusion of feelings preceding it, may be impossible to determine. It is most likely that these form a series of events which naturally accompany each other and which all contribute to any sequelae.

According to the duration of the pregnancy, the abortion procedure used is:

1. Menstrual regulation or menstrual extraction. This simple outpatient procedure is performed in the first 8 to 15 days after missing the onset of the menstrual period (i.e., not more than 6 weeks after the first day of the last menstrual period). A very thin cannula is introduced through the cervix without dilatation, and the contents of the uterus are extracted with a syringe. Often this is performed earlier than a pregnancy test can be reliably done, and hence there is often a doubt whether a pregnancy existed at all; this allows the patient to circumvent religious or ethical problems, and to consider this as "starting a period."

2. Dilatation and Curettage (D & C), or more often, Dilatation and Evacuation (D & E or suction). Either is performed from as early as 10 days after a missed menstrual period to up to 12 weeks of gestation. Local anesthesia is usually used to numb the cervix. Dilatation of the cervix precedes the introduction of a curette in the D & C procedure or of a catheter attached to a suction apparatus for the D & E, to dislodge and remove the uterine contents. This is done on an out-patient basis, and the woman therefore experiences less interruption in her daily routine than with procedures requiring general anesthesia and/or hospitalization.

3. Amniocentesis or saline abortion. This procedure is done when the woman has waited beyond 12 weeks of gestation (and it often is delayed for safety reasons until after 16 weeks of pregnancy). It involves the injection of hypertonic saline solution into the amniotic cavity. Local anesthesia is administered to the injection site. The patient is usually admitted to the hospital and after a variable period of 12 to 48 hours, the uterus undergoes contractions and expels the fetus. More recently, prostaglandins have been used for the second trimester abortion, in a similar procedure.

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Clearly, there will be differences in the emotional impact according to which technique has been used. One of the sources of the stronger emotional impact of a second trimester abortion is that sometimes fetal movements have been felt during the pregnancy, and the fetus is therefore perceived by the woman as being more real and as being alive. In addi-

tion, the expulsion usually involves painful contractions similar but less intense than labor pains in a term delivery. The woman may see the aborted fetus, which at this stage of development has a more baby-like appearance.

Women who allow the pregnancy to continue beyond 12 weeks before seeking an abortion (and who thus require the more traumatic procedures) tend to exhibit certain characteristics. They are, in general, in the younger age range (under 18 years old), and are unmarried. The denial of pregnancy and the fear of telling their parents seem to be very crucial factors. In younger adolescents, the biological irregularity of the menstrual cycle shortly after menarche may add to a delay in diagnosing the pregnancy. Ambivalence about the pregnancy and indecision about whether to carry the pregnancy to term or to terminate it may postpone the application for abortion in all age groups. Sudden changes in the woman's life situation (death of the spouse, separation, disease, financial setback, etc.) may account for some cases of late decision.

The reactions and attitudes of medical and paramedical personnel towards the later abortion procedures and towards these patients have been quite variable. In the past, these may have contributed to the more unpleasant environment for those having second trimester abortions. There have been reports of severe criticism and guilt-induction by such personnel due to their own personal emotional discomfort.(30) Needless to say, the environment immediately surrounding the abortion experience will contribute to the woman's perception of the whole incident.

VI. Follow-up Studies on Psychological Aspects of Abortion

There are several outstanding features in the bulk of the psychiatric literature dealing with follow-up studies on abortion. A great number of papers express opinions from a theoretical, impressionistic point of view, usually with great conviction but with little factual information as to how the procedure helped or hindered the patient. These studies show prevailing views of the period in which they were written, and thus the impact of legalization will be reflected in only the recent studies.

In the forties, fifties and early sixties, with the advance of medical resources, abortion granted on medical grounds to save the mother's life was less often indicated, and the number of therapeutic abortions performed in U.S. hospitals decreased significantly.(31) During that period, a very small number of abortions were performed on psychiatric grounds in individual states which allowed legal abortions if the continuation of the pregnancy was considered to severely impair the physical or mental health of the patient. The degree of psychiatric impairment necessary was variable, but it had to be severe; usually it had to precede the pregnancy.(32) Criteria for granting an abortion ranged from never finding sufficient psychiatric causes for abortion,(33) to the most frequently mentioned criteria of high potential for suicide or psychotic decompensation.(34) Most of the studies were very concerned with the possible negative emotional aftereffects.

During that same period, legal abortions were performed in much larger numbers in several European countries. Follow-up study results from these countries are difficult to generalize from because the laws, the popular acceptance of the procedure, and the indications for a psychiatric recommendation for abortion were all different from those in the United States.

In an attempt to review the literature on the "Psychiatric Sequelae of Abortion," Simon and Senturia(35) covered the years from 1935 to 1964, commenting on the articles with regard to research design, results and conclusions drawn from each report.

In the papers reviewed, the findings and conclusions range from the suggestion that psychiatric illness almost always is the outcome of therapeutic abortion to its virtual absence as a post-abortion complication. In the five European studies that can logically be compared, the findings range from 43% with severe guilt and an additional 12% with psychiatric illness,(36), to 0% in both categories.

Their concluding commentes reflected the inconsistencies found in the psychiatric literature up to that point, but they observed that "There is some agreement that women with diagnosed psychiatric illness prior to abortion continue to have difficulty following abortion."

In the late sixties, a trend toward liberalization started in England and in the U.S., and subsequent studies began to reflect the chanre. During that period, most of the abortions granted in the U.S. were on psychiatric grounds and a very high percentage of women in these samples had previous psychiatric symptoms. Another report by Simon, Senturia and Rothman,(38) in which the psychiatrists did their own follow-up, concluded that serious psychiatric illness following abortion was related to pre-existing psychiatric illness, and was only rarely related to or precipitated by the abortion. The psychiatrically healthier women in the sample handled abortion in more mature and adaptive ways.

Patt et al.(39) followed 35 patients seen from 1964 to 1968 who had abortions on psychiatric grounds. (This was the largest psychiatrically-indicated group in the American literature up until 1969). The majority had favorable short-term effects, while a few had negative reactions lasting from two to six months. Most new symptoms seemed to arise from pre-existing mental illness or from unrelated life stresses, with severe guilt occurring in only two patients who felt that they had been forced into the abortion. Long-term effects were more favorable, with several patients feeling that the experience contributed to their emotional growth, thus leading the authors to conclude that "...with rare exceptions, abortions were genuinely therapeutic." Peck and Marcus⁴⁰ drew similar conclusions with their sample of 50 women, with 92% improved or unchanged.

From England, Clark(41) reported a large study on patients given a abortion on psychiatric grounds, and attempted to refute the notion that psychological damage is inevitable. He also described group work with the medical staff to resolve their personal difficulties in dealing with abortions. Pare(42) confirmed the above opinion, adding that in the patients denied an abortion, psychiatric symptoms appeared, especially in the overburdened mother and the single girl without emotional support. The patients for whom pregnancy was terminated had little psychiatric disturbance provided that the patient herself had made the decision to have an abortion.

As psychiatric criteria widened, women with a lesser degree of or with no psychopathology were included. One of the first reports on patients aborted after passage of liberalized abortion legislation was published in 1970 by Marder et al.(43) Very few patients were reported to have developed severe post-abortion difficulties. The authors compare procedures, finding amniocentesis more traumatic and guilt-producing. They also noted the emotional upheaval of unstable adolescents who gave up their child for adoption. These patients described this experience as the most painful they had endured, and as a source of guilt and depression.

Ewing et al.(44) reported depressed feelings decreasing over time as the most commonly expressed emotional symptom. A high degree of satisfaction was also reported, with only 4% of the patients saying that they would not seek another abortion in similar circumstances. A review of data on psychological reactions of patients seen after New York State's liberalized law, by Osofsky and Osofsky,(45) also indicated a low incidence of sequelae. In addition, it revealed that many women sought abortions who would not have

prior to the greater liberalization and legalization. A greatly increased desire for effective birth control methods was also expressed, rather than the attitude that abortion was now available to be used as contraception. This reports also showed a higher incidence of negative reactions by patients from Catholic backgrounds.

Brody's study(46) was among those using psychological testing as source of data. The Minnesota Multiphasic Personality Inventory was administered both before and after the abortion. Brody concluded that immediately after the event and one year later, most patients were similar to a control group in the psychological profiles derived from this test. A small group of patients who had been denied an abortion showed no change over time and remained markedly disturbed after bearing the unwanted child. A 1971 study(47) also found that after abortion, the patients' MMPI profiles appeared more normal than before it. This study included women from lower socioeconomic backgrounds, a contrast with previous studies which had been almost exclusively composed of uppermiddle class white women.

Niswander et al.(48) raised the question of whether the therapeutic abortion applicant is likely to be psychologically "normal" but emotionally upset by the presence of the unwanted pregnancy, or whether it is the psychologically "abnormal" patient who becomes unhappily pregnant. He confirmed improvement in the psychological state of women, as measured by the MMPI, six months after an abortion as compared with pre-abortion scores, when anxiety, depression and implusivity scales were elevated. The results suggested that abortion significantly reduced psychological stress. Maternity patients facing the prospects of labor and delivery showed some reduction of stress after these respective events as well. Even if abortion patients were less well adjusted, it was found that after the abortion their adjustment was significantly improved. Margolis(49) pointed out that abortions did not tend to aggravate mental illness, and in fact were often helpful to the life adjustment of the patient. Girls in his study under 18 had more ambivalence and guilt. We(50) obtained similar results on MMPI profiles on a sample of early adolescent abortion patients, with depression decreasing and the profiles approaching those of the normative group over time. These test results suggested that the unwanted pregnancy was a source of anxiety and depression, and that once that stress was removed, the person felt relief, revealed on the MMPI as a decrease in scales corresponding to these symptoms. Other characterological problems may also have been aggravated by the crisis situation, and may or may not abate following the abortion.

Smith(51) reported on follow-ups one to two years later on 80 women who had undergone abortions. Symptoms of depression, guilt and sexual dysfunction had been experienced by some of them, but these symptoms were usually self-limited and did not impair the woman's functioning or require professional help. Most patients felt that the abortion had a positive effect on their lives and that it produced growth and made them more mature. Only 3% strongly regretted their decision, and another 3% were ambivalent. Those who regretted it felt that they had been unduly influenced by others. Once again, most of the post-abortion problems appeared in teenagers.

Fingerer(52) postulated that the minor post-abortion psychological disturbances that are observed may be learned responses to the situation, rather than the results of a traumatic event. She concluded from her study that "there is no immediate anxiety after abortion, there is some mild depression, probably a transient situational reaction adjustment. The psychological aftereffects of abortion seem to reside in psychoanalytic theory and societal myths."

Following removal of all prerequisites, the incidence of abortion increased dramatically; the percentage of maternal deaths due to abortion decreased with the replacement of un-

safe criminal abortion by safe, legal procedures; and the ethnic and socioeconomic discriminations in abortion availability were removed.(53) As a consequence, the follow-up literature has begun to include a wider range of women, and reports not only have confirmed the rarity of intense negative reactions, but also have begun to point out the benefits that some patients feel they have obtained.

In California, where the law was liberalized earlier, Monsour and Steward(54) found that post-abortion, the patients felt freer, stronger and more self-responsible. The women were able to re-evaluate their behavior, lives, futures, etc. . . . The predominant feeling expressed was relief, with only one patient of the twenty acknowledging any guilt.

The effects of legalization and liberalization of abortion laws are evident in our own research. We have been concerned with the reactions of early adolescent girls (16 and younger) after abortion. Patterns have begun to change, which we feel may be partially accounted for by liberalization and a concomitant change in attitude toward abortion. The first group followed had had abortions in the late 60's or early 70's, when abortion in the United States (and in North Carolina where they lived), was available only on medical or mental health grounds. The sample included blacks and whites, but was more heavily represented by upper middle class and white families. Some degree of stress was seen prior to and after the abortion, with negative emotional reactions varying in intensity but usually lasting for only a short period of time.(55)

The composition of our follow-up sample since the Supreme Court decision of 1973 favoring abortion on request has revealed that abortion is becoming less of a class privilege than it formerly was. (These results have not yet been published). More black girls, especially those in their very early teens and those who already have a baby, seem to be availing themselves of abortion for unwanted pregnancies. Both black and white applicants in our study are now more frequently from the lower socioeconomic range and have parents with less formal education than was true of our original group. (This is not to say that fewer upper middle class girls are having abortions; they may be going elsewhere, but *this* group was not having them in the past). We feel this indicates that, as a result of liberalization and dispersal of information (particularly through popular magazines) the acceptance of abortion has reached a greater proportion of the population. Sometimes the adolescents have made the decision by themselves, prior to informing their parents of the pregnancy. In addition, they appear less anxious and more confident of a solution to their problem at the pre-abortion interview than they have in the past. Continuation of education is a major emphasis, even when the girl already has reached an educational level higher than her parents did. To have families much smaller than their family of origin is also a frequently expressed desire. In terms of aftereffects, most adolescents now have fewer complaints, although we are beginning to surmise that the black teenagers continue to be more likely to express regret for the loss of the pregnancy and are much more likely to become pregnant again in 2 to 3 years, usually choosing to bear the child.

In summary, most studies now available do not yet reflect the full impact of the change in abortion laws in the U.S. As time elapses since enactment, follow-up studies will probably begin to show that due to changed societal attitudes, women will be under less stress both before and after an abortion. In addition, since a woman no longer needs to appear psychiatrically ill to qualify, abortion studies will contain a more representative group of women. If Fingerer's hypothesis is true—that women have been exhibiting learned behavior in their negative reactions following abortion—then we can also anticipate that societies with liberalized positions will cease inculcating the idea that a woman should feel guilt or shame after abortion, and that these feelings will therefore become

less frequent and less intense. Follow-up studies done since liberalization in the U.S. and England seem to reveal that this is the case.

ABORTION PART 4

VII. Psychological Aftereffects

A. Negative Feelings

Among potential negative reactions following abortion, guilt and depression have been most frequently reported.

Guilt feelings can arise from several sources. A woman may feel self-accusatory for having done an immoral act, expressed as having "killed" a potential child. She may consider herself as bad or as a "condemned person." Guilt feelings may also arise from self-blame for having precipitated a crisis in her relationships with her husband or boyfriend, parents or friends. This crisis may represent a continuum that includes the sexual activity which caused the conception, the pregnancy itself, the decision-making process and the subsequent abortion, rather than the abortion alone. The woman's guilt feelings may also have their source in her thinking that she has denied the father or her parents a baby they might have wanted, but which she herself did not.

The other major class of negative reactions, depressive feelings, may also spring from several sources. The woman may feel unhappy about the loss of the potential baby and of all the benefits she had imagined would accompany its birth, such as a better relationship with its father or her parents, an end to loneliness, an increase in self esteem or a greater sense of purpose in her life. She may be depressed due to self directed anger, as a reversal of the anger felt toward the others who participated in the decision and whom she later perceives (correctly or incorrectly) as having coerced her. Decreased interest in and responsiveness to sexual activity may result as part of the depressive reaction or as repressed hostility toward the male involved. Among women from deprived socioeconomic backgrounds or with little education, ignorance about the procedure they have undergone may lead to feelings of anxiety about what has been done to them. They may feel that they have been damaged in some way, and may wonder if their ability to have children has been impaired.

In general, as the more recent psychiatric literature agrees, when negative feelings do arise, they are most often similar to a mourning process, usually of mild to moderate intensity and of short duration. This would be part of the natural response to the loss of the fetus and to the stress of the medical procedure, and should not be confused with a psychiatrically impairing illness. For women with pre-existing patterns of maladjustment, the pregnancy is an added stress which can be removed by the abortion, but the pattern itself is usually neither aggravated nor improved.

B. Positive Psychological and Social Effects

While all the negative aspects of abortion have been described in detail, little attention has been paid to the potential benefits a woman may receive from her experience. First, of course, it resolves the problem: she does not have to bear the unwanted child. At the same time, she experiences a heightened awareness of her fertility and of her responsibility for both conception and contraception. She becomes more aware of the effect an unplanned pregnancy can have on her life, and this may help her to define more clearly what her goals in life are and how she will achieve them. The abortion has given her another

chance to attain these goals. She may examine her attitudes toward marriage, family size, future education and occupation for the first time, and come to know herself better.

For many of the younger women, this will be the first serious decision they have ever made. From this, the young woman may get a sense of mastery at having gained control over her reproductive life, as compared to the powerlessness many women have felt in the past. The situation may also afford the woman an opening for discussing sexual concerns with others, problems she would perhaps not have resolved without the crisis situation. The crisis may also lead to a new closeness with the important people who rallied around her in her time of need. Alternatively, the reactions of these same persons may lead her to evaluate the relationships she has with them, particularly with the male partner, and to see if there is a need for change.

Some women are ignorant of the functioning of their own bodies, and this experience teaches them about their own anatomy and physiology and what must be done to control conception to ensure the most happiness for themselves and their families. At the time of the procedure, the woman usually learns much about medical care, and especially about contraception.

In addition to providing these positive areas of information and growth, the abortion may also be therapeutic by preventing the harmful effects that the unwanted pregnancy could have produced. Some severe physiological complications of pregnancy (hyperemesis gravidarum in particular) and post-partum psychosis are thought to have their origins to a major degree in the pregnancy's being unwanted.(56,57) The extreme situations of neonaticide and infanticide are rare, but abandonment of the child, battering and failure of the infant to thrive are not uncommon consequences of unwanted births. Besides these obvious manifestations of the mother's rejection, there are multiple and subtle consequences of the disturbed mother-child relationship that are felt to be related to eventual psychiatric illness or psychopathy in the child.

If the woman has children too closely spaced, these children may indirectly benefit from the abortion because it has allowed their mother to avoid further overloading her mothering capacity, and thus protects them from more emotional and/or economic deprivation.

For the woman herself, abortion may free her from entering into an unwise marriage. Marriages occurring at too early an age, especially when precipitated by a pregnancy, are likely to be unhappy and to end in divorce, leaving children with only one parent or possibly torn between two contending parents. Abortion allows the young woman and her family to avoid the stigma of illegitimacy without the tragedy of a forced marriage.

C. Effects of Counseling on Outcome

Whether the woman will experience mainly positive and growth-producing emotions surrounding an abortion or will have an unhappy and traumatic time can be influenced to a significant degree by the counseling she receives both before and after the abortion. Effective counseling will help to spot those individuals who are liable to have a negative experience, and can help to eliminate or lessen the bad effects. It can open up discussion and make the episode more positive for the women who would be less likely to profit from their experience.

Pre-abortion counseling can help the woman to understand the reasons why her unwanted pregnancy occurred. It can allow her to think over her decision, to be certain that it is indeed what she wants. The ideal role of the counselor is to be supportive, empathetic yet objective, and flexible, allowing the woman to present her own points of view rather than imposing his or her own. In addition, as the counselor becomes attuned to the type of person who is likely to have difficulties after abortion, he or she can intervene to

ameliorate the potential problems. Among these persons are women who may really want to have the baby but do not realize it until they have a chance to talk it over; women who feel that they are being coerced into having the abortion by others and who need a neutral party to discuss it more objectively; ambivalent or passive patients who want someone to make the choice for them but who may regret it later, and who need to realize that they must make their own decision; and women who wish that they could continue the pregnancy to term but admit that abortion is the best choice due to external realities. Adolescents, particularly, must come to feel that they have made their own decision in order to avoid negative sequelae.

Although the outcome from abortion is difficult to predict, patients with severe psychiatric illness generally have less ability to cope with any stress, and especially need prior counseling. Women who are likely to receive little moral support from others or even to suffer criticism are in greater danger of eventual distress. By recognizing and discussing problems, the counselor can prevent the occurrence of a great deal of dissatisfaction and regret in these higher risk patients.

Post-abortion counseling can also play a preventive role beyond the immediate post-operative period. Ideally, it focuses on the integration of the experience by allowing the free expression of feelings, and guides the patient toward thinking about future tasks, such as avoiding another unwanted pregnancy. Short-term group therapy with other abortion patients has been found useful in sorting out feelings for many women,(58) and further therapy can be recommended for persons who remain troubled.(59)

The availability of abortion-oriented counseling both before and after the event has been one important result of legality contributing to the lessened aftereffects now being found in follow-up studies.

VIII. Summary: Legality and Its Consequences

After legalization of abortion in the United States, noticeable changes have started to occur. Most prominent are the following:

1. Having an abortion is no longer considered a "crime" by the bulk of society. Women have the opportunity to consider it as an alternative solution for an unwanted pregnancy, and can freely choose to interrupt the pregnancy or carry it to term.

2. The doubts and turmoil engendered by making the decision to have an abortion are less intense and are resolved in a shorter period of time because of the removal of many of the extraneous stresses and because of awareness of the accessibility of the procedure.

3. Medically, abortion now tends to be considered as any other routine procedure, with a certain but minimal percentage of complications.

4. Women have a variety of options about fees and a range of settings which include doctors' offices, hospitals, "women's clinics," and clinics specializing only in abortions. Fee schedules are generally available, removing the uncertainty about the final cost of the procedure, and the financial hardship formerly caused by the fees demanded for both legal and illegal abortions has now been lessened.

5. A woman can now expect to be considered as a person in need of medical attention, rather than to be judged or to have to ask for a favor.

6. When abortion was granted mainly on psychiatric grounds, the woman had to show that she was emotionally disturbed enough to threaten suicide or to have the potential for becoming psychotic; now her simple request to terminate the pregnancy suffices as grounds.

7. There is a slow decrease in social, medical and moral sanctions against abortion

which is reflected in the attitudes of health personnel and their behavior as well as in the public's beliefs and practices.

8. Abortion is becoming available to women from every socioeconomic and educational level, racial background and religious persuasion.

9. Medical insurance policies are expanding to help cover the costs of the procedure, as has government-sponsored coverage for medical expenses.

10. Publicity since legalization has led to abortions being more often performed at an earlier stage, in the first trimester, when the procedure is less traumatic physically and emotionally.

11. Research is now possible, so that improvements can be developed in abortion techniques and in the factors that alleviate stress.

12. Emotional aftereffects of guilt and depression described in the psychiatric literature have decreased in intensity and are resolved in a shorter period of time. In recent studies, feelings of relief seem to outweigh the sadness and guilt described earlier.

13. Publication and communication of the results of recent follow-up studies have helped to dispel the fears caused by previous studies done when abortion was less accepted and more traumatic, and when more negative effects were therefore described.

14. The setting for the abortion can now include facilities for counseling the woman, aiding resolution of the conflict which can occur in the decision-making process.

As we have seen, a woman's acceptance and integration of an abortion into her life experience depends on her emotional make-up and development, the events preceding the pregnancy, the reactions of those around her, and the cultural environment which has shaped and continues to influence her attitudes toward pregnancy and childbearing. When factors favoring termination significantly outweigh circumstances and attitudes favoring continuation of her unwanted pregnancy, the woman will be best satisfied with her decision.

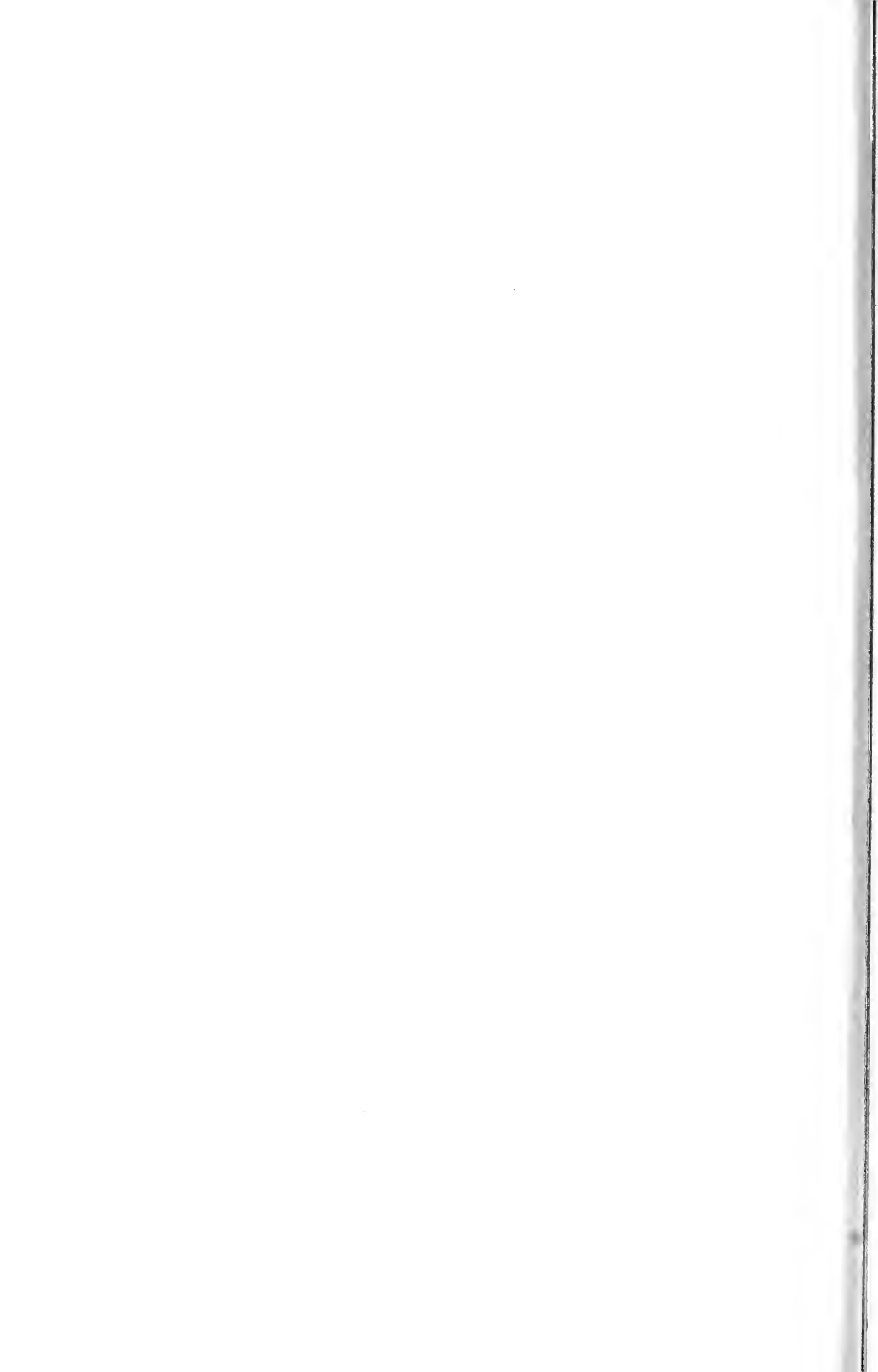
As laws become liberalized, abortion becomes more common and more acceptable. The experience ceases to be regarded as something unusual and abnormal by society, and therefore by the individual woman. As her expectations about her feelings after the abortion become more positive, so will her actual emotions. Consequently, we can expect even fewer negative psychological aftereffects to occur, and more benefits to be reported: feelings of relief and of having been given a "second chance."

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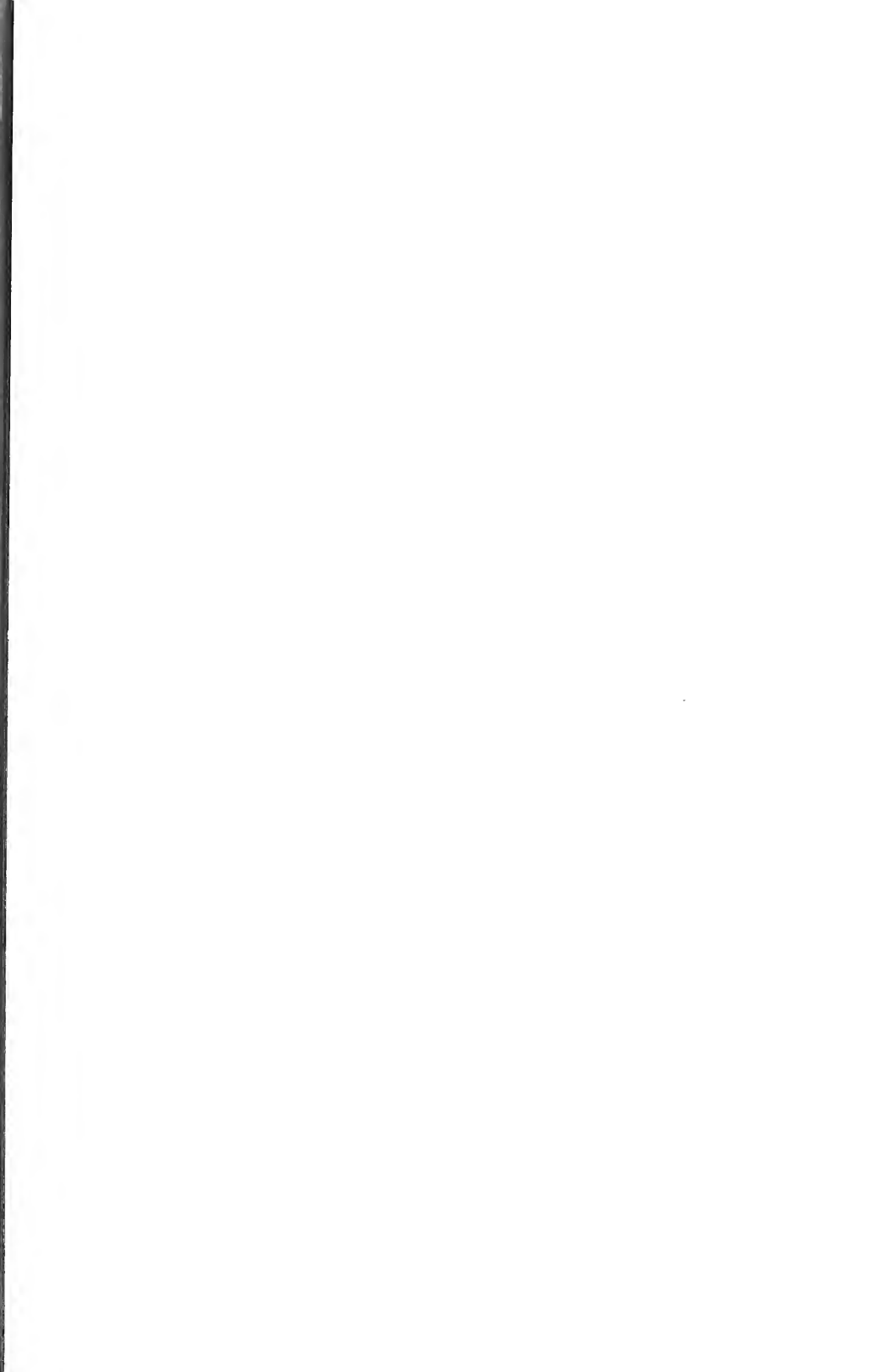
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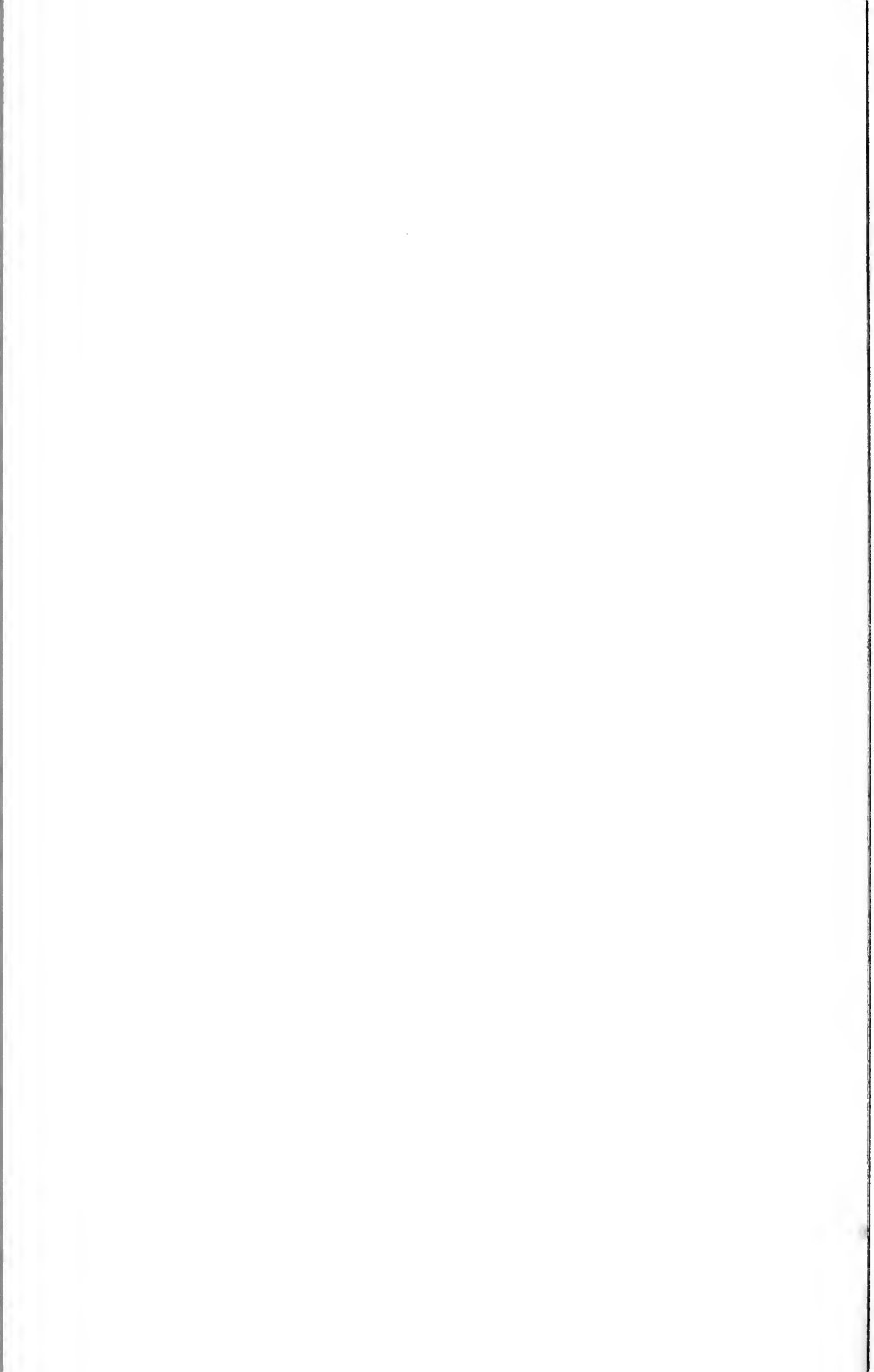
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